

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: OrthoIllinois Surgery Center Elgin, LLC		
Street Address: 2440 Alft Lane		
City and Zip Code: Elgin, 60124		
County: Kane	Health Service Area: HSA8	Health Planning Area: A-11

Applicant(s) [Provide for each applicant (refer to Part 1130.220)]

Exact Legal Name: OrthoIllinois Surgery Center Elgin, LLC
Street Address: 324 Roxbury Road
City and Zip Code: Rockford, IL 61107
Name of Registered Agent: Jan H. Ohlander
Registered Agent Street Address: 2902 McFarland Road Suite 400
Registered Agent City and Zip Code: Rockford, IL 61107
Name of Chief Executive Officer: Anthony Brown
CEO Street Address: 324 Roxbury Road
CEO City and Zip Code: Rockford, IL 61107
CEO Telephone Number: (779) 800-2550

Type of Ownership of Applicants

☐ Non-profit Corporation	☐ Partnership	
☐ For-profit Corporation	☐ Governmental	
☒ Limited Liability Company	☐ Sole Proprietorship	☐ Other
○ Corporations and limited liability companies must provide an Illinois certificate of good standing. ○ Partnerships must provide the name of the state in which they are organized and the name and address of each partner specifying whether each is a general or limited partner.		
APPEND DOCUMENTATION AS ATTACHMENT 1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.		

Primary Contact [Person to receive ALL correspondence or inquiries]

Name: Anthony Brown
Title: Chief Executive Officer
Company Name: OrthoIllinois Surgery Center Elgin, LLC
Address: 324 Roxbury Road, Rockford, IL 61107
Telephone Number: (779) 800-2550
E-mail Address: Anthony.Brown@orthoillinois.com

Additional Contact [Person who is also authorized to discuss the application for permit]

Name: Juan Morado Jr. and Mark J. Silberman
Title: Partner
Company Name: Benesch, Friedlander, Coplan & Aronoff, LLP
Address: 71 South Wacker Drive, 16 th Floor, Chicago IL 60606
Telephone Number: 312-212-4949
E-mail Address: jmorado@beneschlaw.com; msilberman@beneschlaw.com
Fax Number: 312-767-9192

Post Permit Contact

[Person to receive all correspondence after permit issuance-**THIS PERSON MUST BE EMPLOYED BY THE LICENSED HEALTH CARE FACILITY AS DEFINED AT 20 ILCS 3960**]

Name: Anthony Brown
Title: Chief Executive Officer
Company Name: OrthoIllinois Surgery Center Elgin, LLC
Address: 324 Roxbury Road, Rockford, IL 61107
Telephone Number: (779) 800-2550
E-mail Address: Anthony.Brown@orthoillinois.com

Site Ownership

[Provide this information for each applicable site]

Exact Legal Name of Site Owner: ELGIN ACS REAL ESTATE VENTURES LLC
Address of Site Owner: 324 Roxbury Road., Rockford, IL 61107
Street Address or Legal Description of the Site: Proof of ownership or control of the site is to be provided as Attachment 2. Examples of proof of ownership are property tax statements, tax assessor's documentation, deed, notarized statement of the corporation attesting to ownership, an option to lease, a letter of intent to lease, or a lease.
APPEND DOCUMENTATION AS ATTACHMENT 2, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Operating Identity/Licensee

[Provide this information for each applicable facility and insert after this page.]

Exact Legal Name: OrthoIllinois Surgery Center Elgin, LLC			
Address: 2440 Alft Lane, Elgin IL, 60124			
☐	Non-profit Corporation	☐	Partnership
☐	For-profit Corporation	☐	Governmental
☒	Limited Liability Company	☐	Sole Proprietorship
☐		☐	Other
- o Corporations and limited liability companies must provide an Illinois Certificate of Good Standing. - o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner. - o Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.			
APPEND DOCUMENTATION AS ATTACHMENT 3, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Organizational Relationships

Provide (for each applicant) an organizational chart containing the name and relationship of any person or entity who is related (as defined in Part 1130.140). If the related person or entity is participating in the development or funding of the project, describe the interest and the amount and type of any financial contribution.

APPEND DOCUMENTATION AS ATTACHMENT 4, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Flood Plain Requirements

[Refer to application instructions.]

Provide documentation that the project complies with the requirements of Illinois Executive Order #2006-5 pertaining to construction activities in special flood hazard areas. As part of the flood plain requirements, please provide a map of the proposed project location showing any identified floodplain areas. Floodplain maps can be printed at www.FEMA.gov or www.illinoisfloodmaps.org. **This map must be in a readable format.** In addition, please provide a statement attesting that the project complies with the requirements of Illinois Executive Order #2006-5 (<http://www.hfsrb.illinois.gov>). **NOTE:** A SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM has been added at the conclusion of this Application for Permit that must be completed to deem a project complete.

APPEND DOCUMENTATION AS ATTACHMENT 5, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Historic Resources Preservation Act Requirements

[Refer to application instructions.]

Provide documentation regarding compliance with the requirements of the Historic Resources Preservation Act.

APPEND DOCUMENTATION AS ATTACHMENT 6, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

DESCRIPTION OF PROJECT

1. Project Classification

[Check those applicable - refer to Part 1110.20 and Part 1120.20(b)]

Part 1110 Classification :

- ☐ Substantive
- ☒ Non-substantive

2. Narrative Description

In the space below, provide a brief narrative description of the project. Explain **WHAT** is to be done in **State Board defined terms**, **NOT WHY** it is being done. If the project site does NOT have a street address, include a legal description of the site. Include the rationale regarding the project's classification as substantive or non-substantive.

Orthollinois Surgery Center Elgin, LLC is proposing to add 2 operating rooms consisting of 9,951 gross square feet to the existing ASTC located at 2440 Alft Lane, Elgin, IL 60124.

This project is classified as non-substantive, in that it does not involve the establishment of any category of services. However, it requires an expenditure in excess of the capital expenditure threshold, thus making it reviewable by the HFSRB. Following project completion, the ASTC will contain 6 operating rooms.

Project Costs and Sources of Funds

Complete the following table listing all costs (refer to Part 1120.110) associated with the project. When a project or any component of a project is to be accomplished by lease, donation, gift, or other means, the fair market or dollar value (refer to Part 1130.140) of the component must be included in the estimated project cost. If the project contains non-reviewable components that are not related to the provision of health care, complete the second column of the table below. Note, the use and sources of funds must be equal.

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$13,566	\$11,434	\$25,000
Site Survey and Soil Investigation	\$39,275	\$33,100	\$72,375
Site Preparation	\$105,000	\$295,000	\$400,000
Off Site Work	-	-	-
New Construction Contracts	\$2,750,458	\$2,528,154	\$5,278,612
Modernization Contracts	-	-	-
Contingencies	\$275,000	\$275,000	\$550,000
Architectural/Engineering Fees	\$260,000	\$220,000	\$480,000
Consulting and Other Fees	\$488,393	\$411,607	\$900,000
Movable or Other Equipment (not in construction contracts)	\$1,212,537	\$300,000	\$1,512,537
Bond Issuance Expense (project related)	-	-	-
Net Interest Expense During Construction (project related)	\$341,875	\$288,125	\$630,000
Fair Market Value of Leased Space or Equipment	\$2,805,933	\$2,364,777	\$5,170,710
Other Costs to Be Capitalized	\$379,862	\$320,138	\$700,000
Acquisition of Building or Other Property (excluding land)	-	-	-
TOTAL USES OF FUNDS	\$8,671,899	\$7,047,335	\$15,719,234
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	-	-	-
Pledges	-	-	-
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	\$5,865,966	\$4,682,558	\$10,548,524
Leases (fair market value)	\$2,805,933	\$2,364,777	\$5,170,710
Governmental Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	-	-	-
TOTAL SOURCES OF FUNDS	\$8,671,899	\$7,047,335	\$15,719,234
NOTE: ITEMIZATION OF EACH LINE ITEM MUST BE PROVIDED AT ATTACHMENT 7, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.			

Related Project Costs

Provide the following information, as applicable, with respect to any land related to the project that will be or has been acquired during the last two calendar years:

Land acquisition is related to project ☐ Yes ☒ No Purchase Price: NOT APPLICABLE Fair Market Value: NOT APPLICABLE
The project involves the establishment of a new facility or a new category of service ☐ Yes ☒ No If yes, provide the dollar amount of all non-capitalized operating start-up costs (including operating deficits) through the first full fiscal year when the project achieves or exceeds the target utilization specified in Part 1100. Estimated start-up costs and operating deficit cost is NOT APPLICABLE

Project Status and Completion Schedules

For facilities in which prior permits have been issued please provide the permit numbers.
Indicate the stage of the project's architectural drawings: ☐ None or not applicable ☐ Preliminary ☒ Schematics ☐ Final Working
Anticipated project completion date (refer to Part 1130.140): July 1, 2028
Indicate the following with respect to project expenditures or to financial commitments (refer to Part 1130.140): ☐ Purchase orders, leases or contracts pertaining to the project have been executed. ☐ Financial commitment is contingent upon permit issuance. Provide a copy of the contingent "certification of financial commitment" document, highlighting any language related to CON Contingencies ☒ Financial Commitment will occur after permit issuance.
APPEND DOCUMENTATION AS ATTACHMENT 8, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

State Agency Submittals [Section 1130.620(c)]

Are the following submittals up to date as applicable? ☐ Cancer Registry NOT APPLICABLE ☐ APORS NOT APPLICABLE ☒ All formal document requests such as IDPH Questionnaires and Annual Bed Reports been submitted ☒ All reports regarding outstanding permits Failure to be up to date with these requirements will result in the application for permit being deemed incomplete.
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Cost Space Requirements

Provide in the following format, the **Departmental Gross Square Feet (DGSF)** or the **Building Gross Square Feet (BGSF)** and cost. The type of gross square footage either **DGSF** or **BGSF** must be identified. The sum of the department costs **MUST** equal the total estimated project costs. Indicate if any space is being reallocated for a different purpose. Include outside wall measurements plus the departments or area's portion of the surrounding circulation space. **Explain the use of any vacated space.**

Not Reviewable Space [i.e., non-clinical]: means an area for the benefit of the patients, visitors, staff, or employees of a health care facility and not directly related to the diagnosis, treatment, or rehabilitation of persons receiving services from the health care facility. "Non-clinical service areas" include, but are not limited to, chapels; gift shops; newsstands; computer systems; tunnels, walkways, and elevators; telephone systems; projects to comply with life safety codes; educational facilities; student housing; patient, employee, staff, and visitor dining areas; administration and volunteer offices; modernization of structural components (such as roof replacement and masonry work); boiler repair or replacement; vehicle maintenance and storage facilities; parking facilities; mechanical systems for heating, ventilation, and air conditioning; loading docks; and repair or replacement of carpeting, tile, wall coverings, window coverings or treatments, or furniture. Solely for the purpose of this definition, "non-clinical service area" does not include health and fitness centers. [20 ILCS 3960/3]

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
ASTC	\$8,728,362	-	5,400	5,400	-	-	-
Total Clinical	\$8,728,362	-	5,400	5,400	-	-	-
NON-REVIEWABLE							
Administrative	\$6,990,872	-	4,551	4,551	-	-	-
Total Non-clinical	\$6,990,872	-			-	-	-
TOTAL	\$15,719,234	-	9,551	9,551	-	-	-
APPEND DOCUMENTATION AS <u>ATTACHMENT 9</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

Facility Bed Capacity and Utilization

Complete the following chart, as applicable. Complete a separate chart for each facility that is a part of the project and insert the chart after this page. Provide the existing bed capacity and utilization data for the latest **Calendar Year for which data is available**. Include observation days in the patient day totals for each bed service. Any bed capacity discrepancy from the Inventory will result in the application being deemed **incomplete**.

FACILITY NAME: OrthoIllinois Surgery Center Elgin, LLC			CITY: Elgin		
REPORTING PERIOD DATES: From: January 2024 to: December 2024					
Category of Service	Authorized Beds	Admissions	Patient Days	Bed Changes	Proposed Beds
Medical/Surgical	-	-	-	-	-
Obstetrics	-	-	-	-	-
Pediatrics	-	-	-	-	-
Intensive Care	-	-	-	-	-
Comprehensive Physical Rehabilitation	-	-	-	-	-
Acute/Chronic Mental Illness	-	-	-	-	-
Neonatal Intensive Care	-	-	-	-	-
General Long-Term Care	-	-	-	-	-
Specialized Long-Term Care	-	-	-	-	-
Long Term Acute Care	-	-	-	-	-
Other (ASTC)	4 Class C Operating Rooms	1,103 Patients	1,103 Procedures	-	2 Class C Operating Rooms
TOTALS:	4 Class C Operating Rooms	1,103 Patients	1,103 Procedures	-	2 Class C Operating Rooms

CERTIFICATION

The Application must be signed by the authorized representatives of the applicant entity. Authorized representatives are:

- in the case of a corporation, any two of its officers or members of its Board of Directors.
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist).
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist).
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application is filed on the behalf of OrthoIllinois Surgery Center Elgin, LLC in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this Application on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the fee required for this application is sent herewith or will be paid upon request.

SIGNATURE



Tom Stanley, M.D.
PRINTED NAME

Member
PRINTED TITLE

SIGNATURE



Anthony Brown
PRINTED NAME

Chief Executive Officer
PRINTED TITLE

Notarization:

Subscribed and sworn to before me
this 29th day of July


Signature of Notary

Seal

Notarization:

Subscribed and sworn to before me
this 29th day of July


Signature of Notary

Seal

*Insert the EXACT legal name of the applicant



SECTION III. BACKGROUND, PURPOSE OF THE PROJECT, AND ALTERNATIVES - INFORMATION REQUIREMENTS

This Section is applicable to all projects except those that are solely for discontinuation with no project costs.

1110.110(a) – Background of the Applicant

READ THE REVIEW CRITERION and provide the following required information:

BACKGROUND OF APPLICANT

1. A listing of all health care facilities owned or operated by the applicant, including licensing, and certification if applicable.
2. A listing of all health care facilities currently owned and/or operated in Illinois, by any corporate officers or directors, LLC members, partners, or owners of at least 5% of the proposed health care facility.
3. For the following questions, please provide information for each applicant, including corporate officers or directors, LLC members, partners, and owners of at least 5% of the proposed facility. A health care facility is considered owned or operated by every person or entity that owns, directly or indirectly, an ownership interest.
 - a. A certified listing of any adverse action taken against any facility owned and/or operated by the applicant, directly or indirectly, during the three years prior to the filing of the application.
 - b. A certified listing of each applicant, identifying those individuals that have been cited, arrested, taken into custody, charged with, indicted, convicted, or tried for, or pled guilty to the commission of any felony or misdemeanor or violation of the law, except for minor parking violations; or the subject of any juvenile delinquency or youthful offender proceeding. Unless expunged, provide details about the conviction, and submit any police or court records regarding any matters disclosed.
 - c. A certified and detailed listing of each applicant or person charged with fraudulent conduct or any act involving moral turpitude.
 - d. A certified listing of each applicant with one or more unsatisfied judgements against him or her.
 - e. A certified and detailed listing of each applicant who is in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order or directive of any court or governmental agency.
4. Authorization permitting HFSRB and DPH access to any documents necessary to verify the information submitted, including, but not limited to official records of DPH or other State agencies; the licensing or certification records of other states, when applicable; and the records of nationally recognized accreditation organizations. **Failure to provide such authorization shall constitute an abandonment or withdrawal of the application without any further action by HFSRB.**
5. If, during a given calendar year, an applicant submits more than one application for permit, the documentation provided with the prior applications may be utilized to fulfill the information requirements of this criterion. In such instances, the applicant shall attest that the information was previously provided, cite the project number of the prior application, and certify that no changes have occurred regarding the information that has been previously provided. The applicant can submit amendments to previously submitted information, as needed, to update and/or clarify data.

APPEND DOCUMENTATION AS ATTACHMENT 11, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-4) MUST BE IDENTIFIED IN ATTACHMENT 11.

Criterion 1110.110(b) & (d)

PURPOSE OF PROJECT

1. Document that the project will provide health services that improve the health care or well-being of the market area population to be served.
2. Define the planning area or market area, or other relevant area, per the applicant's definition.
3. Identify the existing problems or issues that need to be addressed as applicable and appropriate for the project.
4. Cite the sources of the documentation.
5. Detail how the project will address or improve the previously referenced issues, as well as the population's health status and well-being.
6. Provide goals with quantified and measurable objectives, with specific timeframes that relate to achieving the stated goals **as appropriate**.

For projects involving modernization, describe the conditions being upgraded, if any. For facility projects, include statements of the age and condition of the project site, as well as regulatory citations, if any. For equipment being replaced, include repair and maintenance records.

NOTE: Information regarding the "Purpose of the Project" will be included in the State Board Staff Report.

APPEND DOCUMENTATION AS ATTACHMENT 12, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM. EACH ITEM (1-6) MUST BE IDENTIFIED IN ATTACHMENT 12.

ALTERNATIVES

- 1) Identify **ALL** the alternatives to the proposed project:

Alternative options **must** include:

- A) Proposing a project of greater or lesser scope and cost.
 - B) Pursuing a joint venture or similar arrangement with one or more providers or entities to meet all or a portion of the project's intended purposes; developing alternative settings to meet all or a portion of the project's intended purposes.
 - C) Utilizing other health care resources that are available to serve all or a portion of the population proposed to be served by the project; and
 - D) Provide the reasons why the chosen alternative was selected.
- 2) Documentation shall consist of a comparison of the project to alternative options. The comparison shall address issues of total costs, patient access, quality, and financial benefits in both the short-term (within one to three years after project completion) and long-term. This may vary by project or situation. **FOR EVERY ALTERNATIVE IDENTIFIED, THE TOTAL PROJECT COST AND THE REASONS WHY THE ALTERNATIVE WAS REJECTED MUST BE PROVIDED.**
 - 3) The applicant shall provide empirical evidence, including quantified outcome data that verifies improved quality of care, as available.

APPEND DOCUMENTATION AS ATTACHMENT 13, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IV. PROJECT SCOPE, UTILIZATION, AND UNFINISHED/SHELL SPACE

Criterion 1110.120 - Project Scope, Utilization, and Unfinished/Shell Space

READ THE REVIEW CRITERION and provide the following information:

SIZE OF PROJECT:

1. Document that the amount of physical space proposed for the proposed project is necessary and not excessive. **This must be a narrative and it shall include the basis used for determining the space and the methodology applied.**
2. If the gross square footage exceeds the BGSF/DGSF standards in Appendix B, justify the discrepancy by documenting one of the following:
 - a. Additional space is needed due to the scope of services provided, justified by clinical or operational needs, as supported by published data or studies and certified by the facility's Medical Director.
 - b. The existing facility's physical configuration has constraints or impediments and requires an architectural design that delineates the constraints or impediments.
 - c. The project involves the conversion of existing space that results in excess square footage.
 - d. Additional space is mandated by governmental or certification agency requirements that were not in existence when Appendix B standards were adopted.

Provide a narrative for any discrepancies from the State Standard. A table must be provided in the following format with Attachment 14.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ASTC	5,400	5,400 GSF	0	YES

APPEND DOCUMENTATION AS ATTACHMENT 14, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

PROJECT SERVICES UTILIZATION:

This criterion is applicable only to projects or portions of projects that involve services, functions, or equipment for which HFSRB has established utilization standards or occupancy targets in 77 Ill. Adm. Code 1100.

Document that in the second year of operation, the annual utilization of the service or equipment shall meet or exceed the utilization standards specified in 1110.Appendix B. **A narrative of the rationale that supports the projections must be provided.**

A table must be provided in the following format with Attachment 15.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1	ASTC (2 Operating Room)	799 Procedures	1,566 Hours	> 1,500 Hours	Yes
YEAR 2	ASTC (2 Operating Room)	992 Procedures	1,944 Hours	> 1,500 Hours	Yes

APPEND DOCUMENTATION AS ATTACHMENT 15, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

UNFINISHED OR SHELL SPACE:

Provide the following information:

1. Total gross square footage (GSF) of the proposed shell space.
2. The anticipated use of the shell space, specifying the proposed GSF to be allocated to each department, area, or function.
3. Evidence that the shell space is being constructed due to:
 - a. Requirements of governmental or certification agencies; or
 - b. Experienced increases in the historical occupancy or utilization of those areas proposed to occupy the shell space.
4. Provide:
 - a. Historical utilization for the area for the latest five-year period for which data is available; and
 - b. Based upon the average annual percentage increase for that period, projections of future utilization of the area through the anticipated date when the shell space will be placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 16, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

ASSURANCES:

Submit the following:

1. Verification that the applicant will submit to HFSRB a CON application to develop and utilize the shell space, regardless of the capital thresholds in effect at the time or the categories of service involved.
2. The estimated date by which the subsequent CON application (to develop and utilize the subject shell space) will be submitted; and
3. The anticipated date when the shell space will be completed and placed into operation.

APPEND DOCUMENTATION AS ATTACHMENT 17, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION VI. SERVICE SPECIFIC REVIEW CRITERIA

This Section is applicable to all projects proposing the establishment, expansion, or modernization of categories of service that are subject to CON review, as provided in the Illinois Health Facilities Planning Act [20 ILCS 3960]. It is comprised of information requirements for each category of service, as well as charts for each service, indicating the review criteria that must be addressed for each action (establishment, expansion, and modernization). After identifying the applicable review criteria for each category of service involved, read the criteria, and provide the required information APPLICABLE TO THE CRITERIA THAT MUST BE ADDRESSED:

G. Non-Hospital Based Ambulatory Surgery

Applicants proposing to establish, expand and/or modernize the Non-Hospital Based Ambulatory Surgery category of service must submit the following information.

ASTC Service
☐ Cardiovascular
☐ Colon and Rectal Surgery
☐ Dermatology
☐ General Dentistry
☐ General Surgery
☐ Gastroenterology
☐ Neurological Surgery
☐ Nuclear Medicine
☐ Obstetrics/Gynecology
☐ Ophthalmology
☐ Oral/Maxillofacial Surgery
☒ Orthopedic Surgery
☐ Otolaryngology
☒ Pain Management
☐ Physical Medicine and Rehabilitation
☐ Plastic Surgery
☒ Podiatric Surgery
☐ Radiology
☐ Thoracic Surgery
☐ Urology
☐ Other _____

3. READ the applicable review criteria outlined below and **submit the required documentation for the criteria:**

APPLICABLE REVIEW CRITERIA	Establish New ASTC or Service	Expand Existing Service
1110.235(c)(2)(B) – Service to GSA Residents	X	X

1110.235(c)(3) – Service Demand – Establishment of an ASTC or Additional ASTC Service	X	
1110.235(c)(4) – Service Demand – Expansion of Existing ASTC Service		X
1110.235(c)(5) – Treatment Room Need Assessment	X	X
1110.235(c)(6) – Service Accessibility	X	
1110.235(c)(7)(A) – Unnecessary Duplication/Maldistribution	X	
1110.235(c)(7)(B) – Maldistribution	X	
1110.235(c)(7)(C) – Impact to Area Providers	X	
1110.235(c)(8) – Staffing	X	X
1110.235(c)(9) – Charge Commitment	X	X
1110.235(c)(10) – Assurances	X	X

APPEND DOCUMENTATION AS ATTACHMENT 25, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The following Sections **DO NOT** need to be addressed by the applicants or co-applicants responsible for funding or guaranteeing the funding of the project if the applicant has a bond rating of A- or better from Fitch's or Standard and Poor's rating agencies, or A3 or better from Moody's (the rating shall be affirmed within the latest 18-month period prior to the submittal of the application):

- Section 1120.120 Availability of Funds – Review Criteria
- Section 1120.130 Financial Viability – Review Criteria
- Section 1120.140 Economic Feasibility – Review Criteria, subsection (a)

VII. 1120.120 - AVAILABILITY OF FUNDS

The applicant shall document those financial resources shall be available and be equal to or exceed the estimated total project cost plus any related project costs by providing evidence of sufficient financial resources from the following sources, as applicable [**Indicate the dollar amount to be provided from the following sources**]:

_____	a)	Cash and Securities – statements (e.g., audited financial statements, letters from financial institutions, board resolutions) as to:
	1)	the amount of cash and securities available for the project, including the identification of any security, its value and availability of such funds; and
	2)	interest to be earned on depreciation account funds or to be earned on any asset from the date of applicant's submission through project completion.
_____	b)	Pledges – for anticipated pledges, a summary of the anticipated pledges showing anticipated receipts and discounted value, estimated timetable of gross receipts and related fundraising expenses, and a discussion of past fundraising experience.
_____	c)	Gifts and Bequests – verification of the dollar amount, identification of any conditions of use, and the estimated timetable of receipts.
\$15,719,234	d)	Debt – a statement of the estimated terms and conditions (including the debt time, variable or permanent interest rates over the debt time, and the anticipated repayment schedule) for any interim and for the permanent financing proposed to fund the project, including:
	1)	For general obligation bonds, proof of passage of the required referendum or evidence that the governmental unit has the authority to issue the bonds and evidence of the dollar amount of the issue, including any discounting anticipated.
	2)	For revenue bonds, proof of the feasibility of securing the specified amount and interest rate.
	3)	For mortgages, a letter from the prospective lender attesting to the expectation of making the loan in the amount and time indicated, including the anticipated interest rate and any conditions associated with the mortgage, such as, but not limited to, adjustable interest rates, balloon payments, etc.
	4)	For any lease, a copy of the lease, including all the terms and conditions, including any purchase options, any capital improvements to the property and provision of capital equipment.
	5)	For any option to lease, a copy of the option, including all terms and conditions.

_____	e) Governmental Appropriations – a copy of the appropriation Act or ordinance accompanied by a statement of funding availability from an official of the governmental unit. If funds are to be made available from subsequent fiscal years, a copy of a resolution or other action of the governmental unit attesting to this intent.
_____	f) Grants – a letter from the granting agency as to the availability of funds in terms of the amount and time of receipt.
_____	g) All Other Funds and Sources – verification of the amount and type of any other funds that will be used for the project.
\$15,719,234	TOTAL FUNDS AVAILABLE
APPEND DOCUMENTATION AS <u>ATTACHMENT 34</u>, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.	

SECTION VIII. 1120.130 - FINANCIAL VIABILITY

All the applicants and co-applicants shall be identified, specifying their roles in the project funding, or guaranteeing the funding (sole responsibility or shared) and percentage of participation in that funding.

Financial Viability Waiver

The applicant is not required to submit financial viability ratios if:

1. "A" Bond rating or better
2. All the project's capital expenditures are completely funded through internal sources
3. The applicant's current debt financing or projected debt financing is insured or anticipated to be insured by MBIA (Municipal Bond Insurance Association Inc.) or equivalent
4. The applicant provides a third-party surety bond or performance bond letter of credit from an A rated guarantor.

See Section 1120.130 Financial Waiver for information to be provided

APPEND DOCUMENTATION AS ATTACHMENT 35, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

The applicant or co-applicant that is responsible for funding or guaranteeing funding of the project shall provide viability ratios for the latest three years for which **audited financial statements are available and for the first full fiscal year at target utilization, but no more than two years following project completion**. When the applicant's facility does not have facility specific financial statements and the facility is a member of a health care system that has combined or consolidated financial statements, the system's viability ratios shall be provided. If the health care system includes one or more hospitals, the system's viability ratios shall be evaluated for conformance with the applicable hospital standards.

	Historical 3 Years			Projected
Enter Historical and/or Projected Years:				
Current Ratio				
Net Margin Percentage				
Percent Debt to Total Capitalization				
Projected Debt Service Coverage				
Days Cash on Hand				
Cushion Ratio				

Provide the methodology and worksheets utilized in determining the ratios detailing the calculation and applicable line item amounts from the financial statements. Complete a separate table for each co-applicant and provide worksheets for each.

Variance

Applicants not in compliance with any of the viability ratios shall document that another organization, public or private, shall assume the legal responsibility to meet the debt obligations should the applicant default.

APPEND DOCUMENTATION AS ATTACHMENT 36, IN NUMERICAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION IX. 1120.140 - ECONOMIC FEASIBILITY

This section is applicable to all projects subject to Part 1120.

A. Reasonableness of Financing Arrangements

The applicant shall document the reasonableness of financing arrangements by submitting a notarized statement signed by an authorized representative that attests to one of the following:

- 1) That the total estimated project costs and related costs will be funded in total with cash and equivalents, including investment securities, unrestricted funds, received pledge receipts and funded depreciation; or
- 2) That the total estimated project costs and related costs will be funded in total or in part by borrowing because:
 - A) A portion or all the cash and equivalents must be retained in the balance sheet asset accounts to maintain a current ratio of at least 2.0 times for hospitals and 1.5 times for all other facilities; or
 - B) Borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

B. Conditions of Debt Financing

This criterion is applicable only to projects that involve debt financing. The applicant shall document that the conditions of debt financing are reasonable by submitting a notarized statement signed by an authorized representative that attests to the following, as applicable:

- 1) That the selected form of debt financing for the project will be at the lowest net cost available.
- 2) That the selected form of debt financing will not be at the lowest net cost available but is more advantageous due to such terms as prepayment privileges, no required mortgage, access to additional indebtedness, term (years), financing costs and other factors.
- 3) That the project involves (in total or in part) the leasing of equipment or facilities and that the expenses incurred with leasing a facility or equipment are less costly than constructing a new facility or purchasing new equipment.

C. Reasonableness of Project and Related Costs

Read the criterion and provide the following:

1. Identify each department or area impacted by the proposed project and provide a cost and square footage allocation for new construction and/or modernization using the following format (insert after this page).

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (List below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
ASTC	\$509.34	-	5,400	-	-	-	\$2,750,458	-	\$2,750,458
Contingency	\$50.92	-	-	-	-	-	\$275,000	-	\$275,000
TOTALS	\$560.26	-	5,400	-	-	-	\$3,025,458	-	\$3,025,458

* Include the percentage (%) of space for circulation

D. Projected Operating Costs

The applicant shall provide the projected direct annual operating costs (in current dollars per equivalent patient day or unit of service) for the first full fiscal year at target utilization but no more than two years following project completion. Direct cost means the fully allocated costs of salaries, benefits and supplies for the service.

E. Total Effect of the Project on Capital Costs

The applicant shall provide the total projected annual capital costs (in current dollars per equivalent patient day) for the first full fiscal year at target utilization but no more than two years following project completion.

APPEND DOCUMENTATION AS ATTACHMENT 37, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. SAFETY NET IMPACT STATEMENT – NOT APPLICABLE

SAFETY NET IMPACT STATEMENT that describes all the following must be submitted for **ALL SUBSTANTIVE PROJECTS AND PROJECTS TO DISCONTINUE HEALTH CARE FACILITIES** [20 ILCS 3960/5.4]:

1. The project's material impact, if any, on essential safety net services in the community, **including the impact on racial and health care disparities in the community**, to the extent that it is feasible for an applicant to have such knowledge.
2. The project's impact on the ability of another provider or health care system to cross-subsidize safety net services, if reasonably known to the applicant.
3. How the discontinuation of a facility or service might impact the remaining safety net providers in each community, if reasonably known by the applicant.

Safety Net Impact Statements shall also include all the following:

1. For the 3 fiscal years prior to the application, a certification describing the amount of charity care provided by the applicant. The amount calculated by hospital applicants shall be in accordance with the reporting requirements for charity care reporting in the Illinois Community Benefits Act. Non-hospital applicants shall report charity care, at cost, in accordance with an appropriate methodology specified by the Board.
2. For the 3 fiscal years prior to the application, a certification of the amount of care provided to Medicaid patients. Hospital and non-hospital applicants shall provide Medicaid information in a manner consistent with the information reported each year to the Illinois Department of Public Health regarding "Inpatients and Outpatients Served by Payor Source" and "Inpatient and Outpatient Net Revenue by Payor Source" as required by the Board under Section 13 of this Act and published in the Annual Hospital Profile.
3. Any information the applicant believes is directly relevant to safety net services, including information regarding teaching, research, and any other service.

A table in the following format must be provided as part of Attachment 37.

Safety Net Information per PA 96-0031			
CHARITY CARE			
Charity (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Charity (cost in dollars)	Year	Year	Year
Inpatient			
Outpatient			
Total			
MEDICAID			
Medicaid (# of patients)	Year	Year	Year
Inpatient			
Outpatient			
Total			
Medicaid (revenue)	Year	Year	Year
Inpatient			

	Outpatient				
	Total				

APPEND DOCUMENTATION AS ATTACHMENT 38, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION X. CHARITY CARE INFORMATION

Charity Care information **MUST** be furnished for **ALL** projects [1120.20(c)].

1. All applicants and co-applicants shall indicate the amount of charity care for the latest three **audited** fiscal years, the cost of charity care and the ratio of that charity care cost to net patient revenue.
2. If the applicant owns or operates one or more facilities, the reporting shall be for each individual facility located in Illinois. If charity care costs are reported on a consolidated basis, the applicant shall provide documentation as to the cost of charity care; the ratio of that charity care to the net patient revenue for the consolidated financial statement; the allocation of charity care costs; and the ratio of charity care cost to net patient revenue for the facility under review.
3. If the applicant is not an existing facility, it shall submit the facility's projected patient mix by payer source, anticipated charity care expense and projected ratio of charity care to net patient revenue by the end of its second year of operation.

Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer (20 ILCS 3960/3). Charity Care **must** be provided at cost.

A table in the following format must be provided for all facilities as part of Attachment 39.

CHARITY CARE			
	2022	2023	2024
Net Patient Revenue	-	-	\$9,057,408
Amount of Charity Care (charges)	-	-	\$6,224
Cost of Charity Care	-	-	-

APPEND DOCUMENTATION AS **ATTACHMENT 39**, IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

SECTION XI -SPECIAL FLOOD HAZARD AREA AND 500-YEAR FLOODPLAIN DETERMINATION FORM

In accordance with Executive Order 2006-5 (EO 5), the Health Facilities & Services Review Board (HFSRB) must determine if the site of the CRITICAL FACILITY, as defined in EO 5, is in a mapped floodplain (Special Flood Hazard Area) or a 500-year floodplain. All state agencies are required to ensure that before a permit, grant or a development is planned or promoted, the proposed project meets the requirements of the Executive Order, including compliance with the National Flood Insurance Program (NFIP) and state floodplain regulation.

1. Applicant: OrthoIllinois Surgery Center Elgin, LLC 324 Roxbury Road
(Name) (Address)
Rockford Illinois 61107 815-484-6915
(City) (State) (ZIP Code) (Telephone Number)

2. Project Location: 2440 Alft Lane Elgin, IL 60124
(Address) (City) (State)
Kane Dundee
(County) (Township) (Section)

3. You can create a small map of your site showing the FEMA floodplain mapping using the FEMA Map Service Center website (<https://msc.fema.gov/portal/home>) by entering the address for the property in the Search bar. If a map, like that shown on page 2 is shown, select the **Go to NFHL Viewer** tab above the map. You can print a

copy of the floodplain map by selecting the  icon in the top corner of the page. Select the pin tool icon  and place a pin on your site. Print a FIRMETTE size image.

If there is no digital floodplain map available select the **View/Print FIRM** icon above the aerial photo. You will then need to use the Zoom tools provided to locate the property on the map and use the **Make a FIRMette** tool to create a pdf of the floodplain map.

IS THE PROJECT SITE LOCATED IN A SPECIAL FLOOD HAZARD AREA: Yes___ No X

IS THE PROJECT SITE LOCATED IN THE 500-YEAR FLOOD PLAIN? No

If you are unable to determine if the site is in the mapped floodplain or 500-year floodplain, contact the county or the local community building or planning department for assistance.

If the determination is being made by a local official, please complete the following:

FIRM Panel Number: _____ Effective Date: _____

Name of Official: _____ Title: _____

Business/Agency: _____ Address: _____

(City) (State) (ZIP Code) (Telephone Number)

Signature: _____ Date: _____

NOTE: This finding only means that the property in question is or is not in a Special Flood Hazard Area or a 500-year floodplain as designated on the map noted above. It does not constitute a guarantee that the property will or will not be flooded or be subject to local drainage problems.

If you need additional help, contact the Illinois Statewide Floodplain Program at 217/782-4428

After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	26
2	Site Ownership	27-28
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	29-30
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	31
5	Flood Plain Requirements	32-33
6	Historic Preservation Act Requirements	34-39
7	Project and Sources of Funds Itemization	40-44
8	Financial Commitment Document if required	45
9	Cost Space Requirements	46
11	Background of the Applicant	47-54
12	Purpose of the Project	55-88
13	Alternatives to the Project	89-90
14	Size of the Project	91
15	Project Service Utilization	92-93
16	Unfinished or Shell Space	94
17	Assurances for Unfinished/Shell Space	95
24	Non-Hospital Based Ambulatory Surgery	96-117
33	Availability of Funds	118-123
36	Economic Feasibility	124-126
37	Safety Net Impact Statement	127
38	Charity Care Information	128
39	Flood Plain Information	129-130

Attachment 1
Certificate of Good Standing Orthollinois Surgery Center Elgin, LLC

File Number 0872271-4



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the

Department of Business Services. I certify that

ORTHOILLINOIS SURGERY CENTER ELGIN, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON MAY 27, 2020, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



Authentication #: 2618500574 verifiable until 07/04/2027
Authenticate at: <https://www.ilsos.gov>

In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 4TH
day of JULY A.D. 2026 .


SECRETARY OF STATE

Attachment 2 Site Ownership

The current owner of the building is Elgin ACS Real Estate Ventures LLC. A copy of their property tax bill is enclosed as evidence of control over the site. The underlying lease between the licensee and the property owner will be amended if this project is approved. The amendment would call for the licensee to pay \$48.55 per gross square foot in year one with a 1.5% escalator over a 10-year period.

Attachment 2 Site Ownership

To view current assessment information, use the Tax Year dropdown to select the current year.

Property Information			
Parcel Number 03-31-277-070	Site Address 2440 ALFT LN ELGIN, IL 60124	Owner Name & Address ELGIN ACS REAL ESTATE VENTURES LLC 324 ROXBURY RD ROCKFORD, IL 61107-5090	
Tax Year 2025 (Payable 2026) ▼			
Sale Status None			
Property Class 0060 - Commercial	Tax Code DU020 -	Tax Status Taxable	
Net Taxable Value 3,331,146	Tax Rate 7.487028	Total Tax \$249,403.84 Pay Taxes Print Tax Bill	
Township DUNDEE	Acres 0.0000	Mailing Address ELGIN ACS REAL ESTATE VENTURES LLC 324 ROXBURY RD ROCKFORD, IL 61107-5090	
Legal Description (not for use in deeds or other transactional documents) CLAYMART SUB LT 2 (EX PT DESC IN DOC 2023K039117 FOR RD ROW)			

Billing									
Installment	Date Due	Tax Billed	Penalty Billed	Cost Billed	Drainage Billed	Total Billed	Amount Paid	Date Paid	Total Unpaid
1	06/01/2026	\$124,701.92	\$0.00	\$0.00	\$0.00	\$124,701.92	\$124,701.92	6/1/2026	\$0.00
2	09/01/2026	\$124,701.92	\$0.00	\$0.00	\$0.00	\$124,701.92	\$0.00		\$124,701.92
Total		\$249,403.84	\$0.00	\$0.00	\$0.00	\$249,403.84	\$124,701.92		\$124,701.92

Payment History			
Tax Year	Total Billed	Total Paid	Amount Unpaid
2025	\$249,403.84	\$124,701.92	\$124,701.92
2024	\$244,744.48	\$244,744.48	\$0.00

Mimecast for Outlook

Attachment 3

Operating Entity/Licensee

OrthoIllinois Surgery Center Elgin, LLC, is licensed by the Illinois Department of Public Health and is certified with the Centers for Medicare and Medicaid Services. Attached as evidence of the owner entity's good standing is a Certificate of Good Standing issued by the Illinois Secretary of State

Attachment 3
Operating Entity
Certificate of Good Standing – OrthoIllinois Surgery Center Elgin, LLC

File Number

0872271-4



To all to whom these Presents Shall Come, Greeting:

I, Alexi Giannoulis, Secretary of State of the State of Illinois, do hereby certify that I am the keeper of the records of the Department of Business Services. I certify that

ORTHOILLINOIS SURGERY CENTER ELGIN, LLC, HAVING ORGANIZED IN THE STATE OF ILLINOIS ON MAY 27, 2020, APPEARS TO HAVE COMPLIED WITH ALL PROVISIONS OF THE LIMITED LIABILITY COMPANY ACT OF THIS STATE, AND AS OF THIS DATE IS IN GOOD STANDING AS A DOMESTIC LIMITED LIABILITY COMPANY IN THE STATE OF ILLINOIS.



Authentication #: 2618500574 verifiable until 07/04/2027
Authenticate at: <https://www.ilsos.gov>

In Testimony Whereof, I hereto set
my hand and cause to be affixed the Great Seal of
the State of Illinois, this 4TH
day of JULY A.D. 2026 .


SECRETARY OF STATE

Attachment 4 Organizational Chart

OrthoIllinois Surgery Center Elgin, LLC

Member Ownership (Each Member: 3.85%)

Brian Bear, MD 3.85%	Frank Bohnenkamp, MD 3.85%	John Bottros, MD 3.85%
Kevin Carlile, MD 3.85%	John Daniels, MD 3.85%	Jeffrey Earhart, MD 3.85%
Scott Ferry, MD 3.85%	Brian Foster, MD 3.85%	Zach Goldstein, MD 3.85%
Michael Harvey, MD 3.85%	Rolando Izquierdo, MD 3.85%	Jeffrey Kazaglis, MD 3.85%
Kenneth Korcek, MD 3.85%	Cort Lawton, MD 3.85%	Anthony Logli, MD 3.85%
Mark Oyer, MD 3.85%	Shawn Palmer, DO 3.85%	Jeremy Pflederer, MD 3.85%
Mike Roh, MD 3.85%	Edric Schwartz, MD 3.85%	Chris Sliva, MD 3.85%
Tom Stanley, MD 3.85%	Scott Trenhaile, MD 3.85%	Geoffrey Van Thiel, MD 3.85%
Jon Whitehurst, MD 3.85%	Marc Zussman, MD 3.85%	

Attachment 5 Flood Plain Requirements



July 29, 2026

John P. Kniery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W Jefferson Street, Floor 2
Springfield, IL 62761

Re: OrthoIllinois Surgery Center Elgin - Flood Plain Requirements

Dear Mr. Kniery:

As representative of OrthoIllinois Surgery Center Elgin, LLC, I, Anthony Brown., affirm that our proposed site complies with Illinois Executive Order #2005-5. The site located at 2440 Alft Ln, Elgin, Illinois, 60124 is not located in a flood plain, as evidence please find enclosed a map from the Federal Emergency Management Agency ("FEMA").

I hereby certify this is true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

Anthony Brown
Chief Executive Officer
OrthoIllinois

CLINIC LOCATIONS

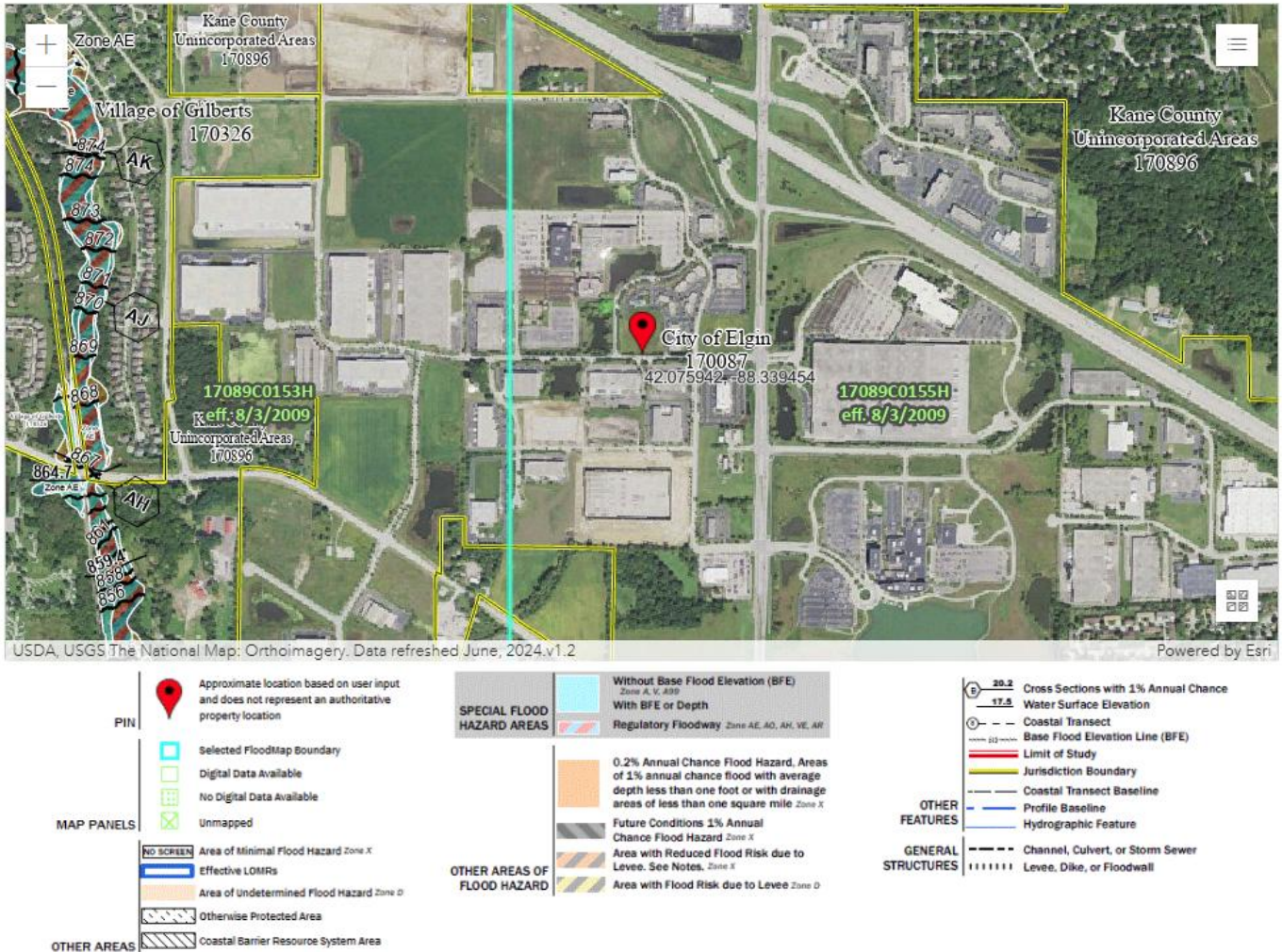
ALGONQUIN
650 S. Randall Rd.

ELGIN
1550 N. Randall Rd.

MCHENRY
411 W. Shamrock Ln., Suite 103

ROCKFORD
2902 McFarland Rd., #300
5875 E. Riverside Blvd.
324 Roxbury Rd.

Attachment 5 Flood Plain Requirements



Attachment 6
Historic Preservation Requirements

September 28, 2026

VIA USPS

Jeffery Kruchten
Chief Archaeologist
Illinois Department of Natural Resources
Attn: State Historic Preservation Office
1 Natural Resources Way
Springfield, IL 62702
SHPO.Review@illinois.gov

**Re: Certificate of Need Application for Ambulatory Surgical Treatment Center-
OrthoIllinois Surgery Center Elgin, LLC**

Dear Jeffrey:

I am writing on behalf of my client, OrthoIllinois Surgery Center Elgin, LLC, to request a review of the project area pursuant to Section 4 of the Illinois State Agency Historic Resources Preservation Act (20 ILCS 3420/1 et seq.). OrthoIllinois Surgery Center Elgin, LLC is in the process of submitting an application for a Certificate of Need to the Illinois Health Facilities and Services Review Board to add additional operating rooms to their existing ambulatory surgical treatment center specializing in located at 2440 Alft Lane, Elgin, Illinois 60124.

The ambulatory surgical treatment center will consist of six (6) total operating rooms, associated recovery areas, and administrative space. For your reference, enclosed are photographs of the existing facility, an aerial map, and a topographic map (Attachments 1-3) depicting the general location and project area.

We respectfully request your review of the project area and issuance of a determination letter at your earliest convenience. Thank you in advance for your time and consideration of this request.

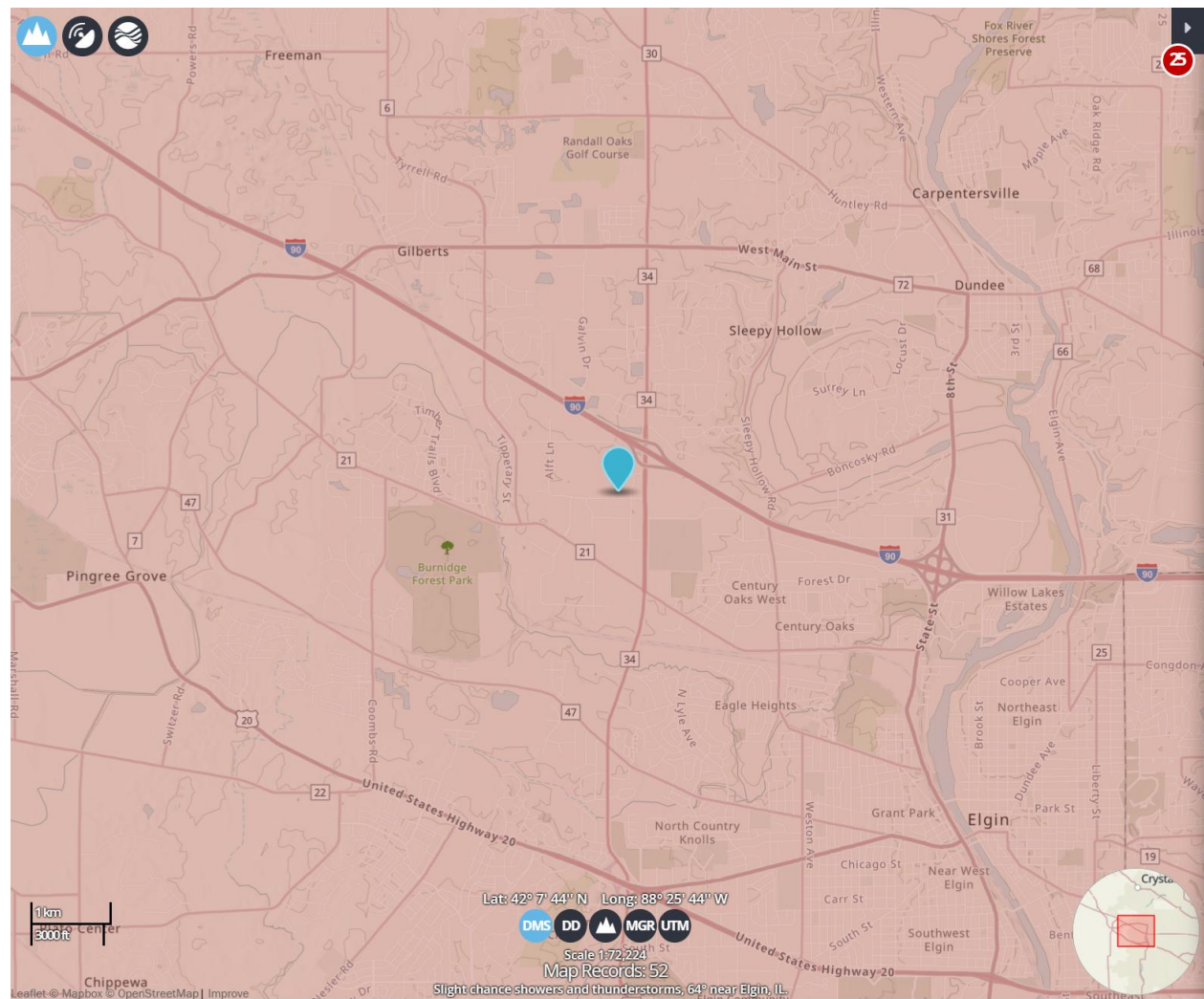
Very truly yours,

BENESCH, FRIEDLANDER,
COPLAN & ARONOFF LLP



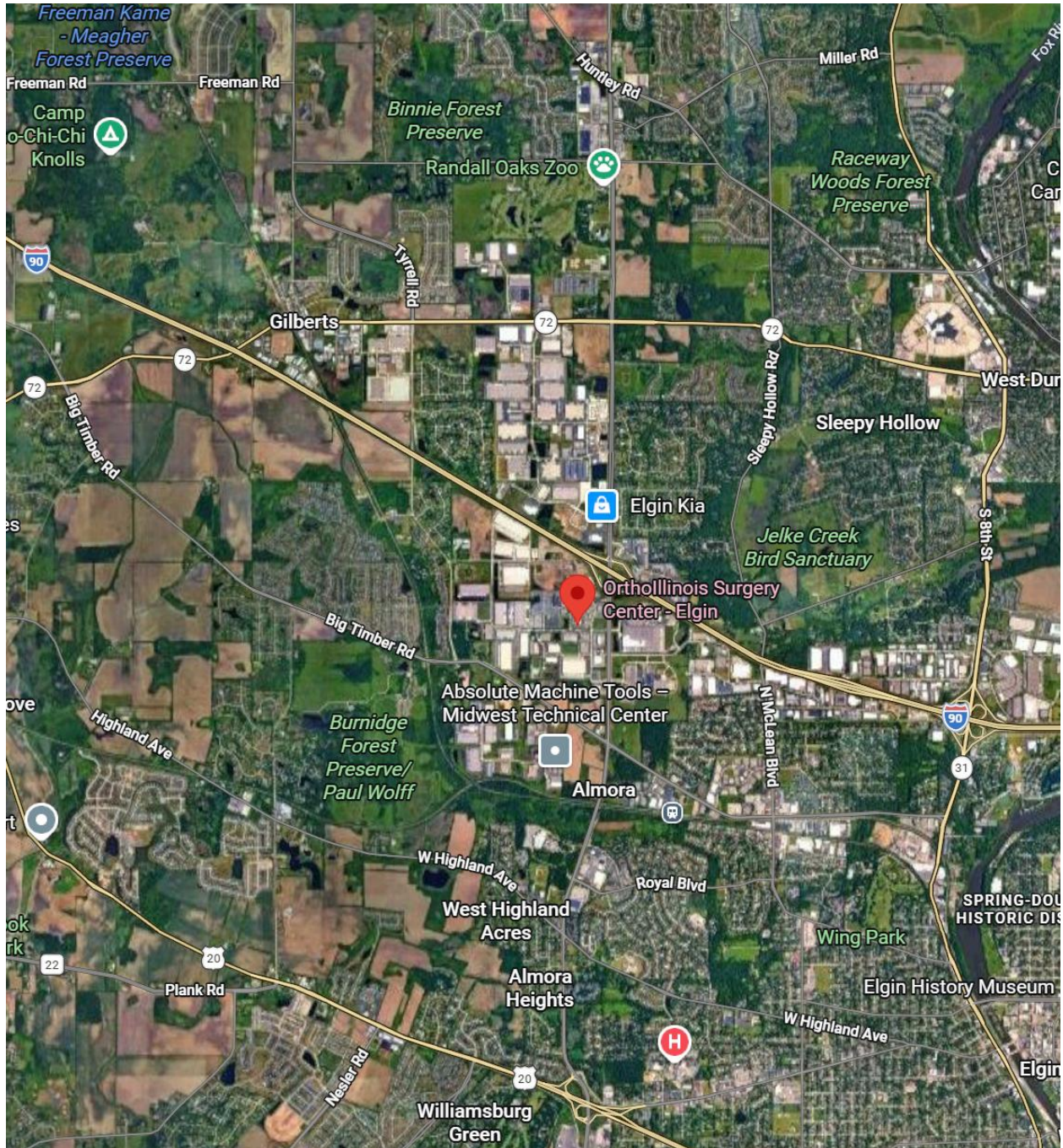
Juan Morado, Jr.

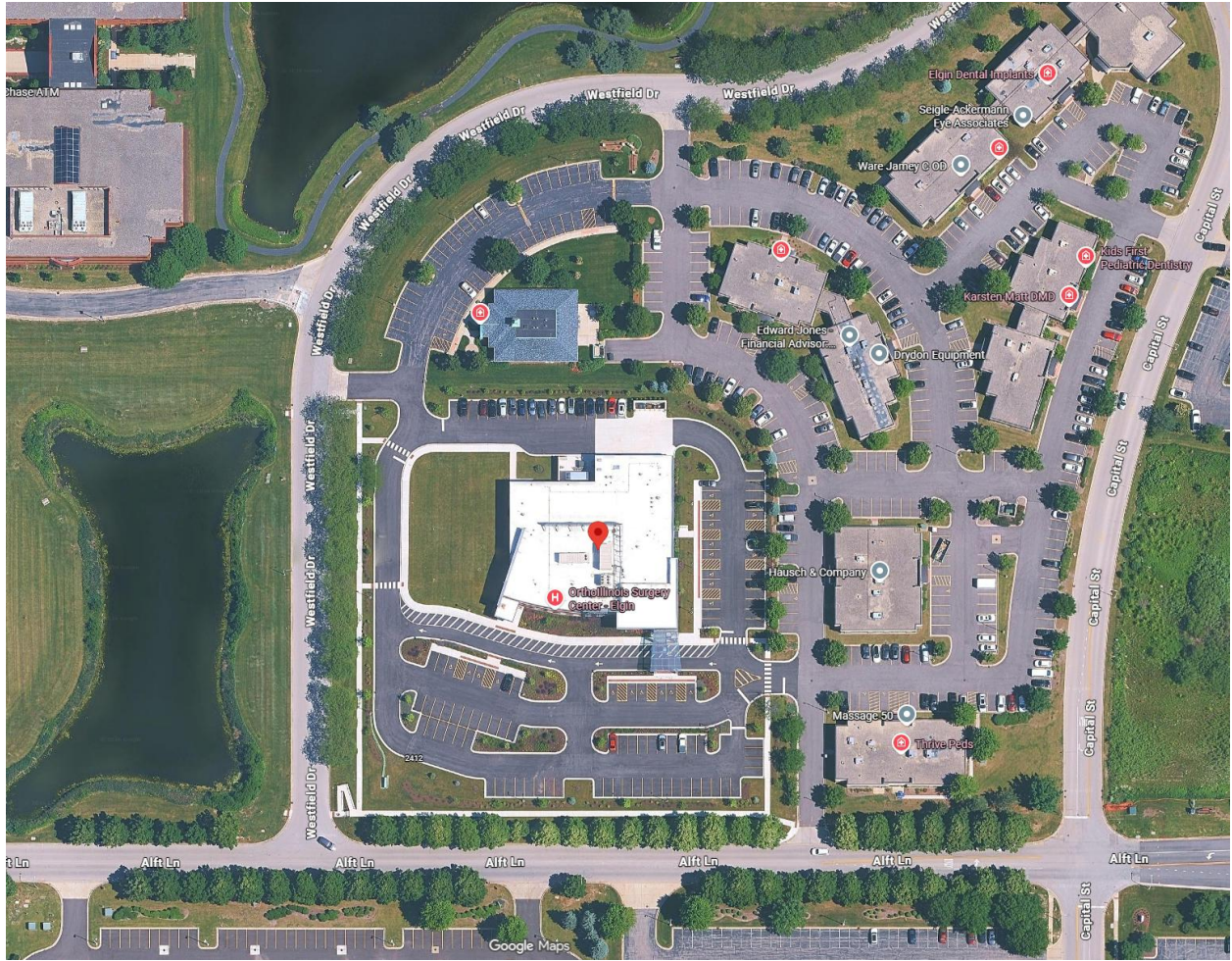
Attachment 6
Historic Preservation Requirements
Topographic Map



Attachment 6 Historic Preservation Requirements

3D Aerial Map





Attachment 6 Historic Preservation Requirements

Aerial Rendering



Attachment 6
Historic Preservation Requirements
Street View



Attachment 7

Project and Sources of Funds Itemization

Project Costs and Sources of Funds			
USE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Preplanning Costs	\$13,566	\$11,434	\$25,000
Site Survey and Soil Investigation	\$39,275	\$33,100	\$72,375
Site Preparation	\$105,000	\$295,000	\$400,000
Off Site Work	-	-	-
New Construction Contracts	\$2,750,458	\$2,528,154	\$5,278,612
Modernization Contracts	-	-	-
Contingencies	\$275,000	\$275,000	\$550,000
Architectural/Engineering Fees	\$260,000	\$220,000	\$480,000
Consulting and Other Fees	\$488,393	\$411,607	\$900,000
Movable or Other Equipment (not in construction contracts)	\$1,212,537	\$300,000	\$1,512,537
Bond Issuance Expense (project related)	-	-	-
Net Interest Expense During Construction (project related)	\$341,875	\$288,125	\$630,000
Fair Market Value of Leased Space or Equipment	\$2,805,933	\$2,364,777	\$5,170,710
Other Costs to Be Capitalized	\$379,862	\$320,138	\$700,000
Acquisition of Building or Other Property (excluding land)	-	-	-
TOTAL USES OF FUNDS	\$8,671,899	\$7,047,335	\$15,719,234
SOURCE OF FUNDS	CLINICAL	NONCLINICAL	TOTAL
Cash and Securities	-	-	-
Pledges	-	-	-
Gifts and Bequests	-	-	-
Bond Issues (project related)	-	-	-
Mortgages	\$5,865,966	\$4,682,558	\$10,548,524
Leases (fair market value)	\$2,805,933	\$2,364,777	\$5,170,710
Governmental Appropriations	-	-	-
Grants	-	-	-
Other Funds and Sources	-	-	-
TOTAL SOURCES OF FUNDS	\$8,671,899	\$7,047,335	\$15,719,234

Attachment 7

Project and Sources of Funds Itemization

Preplanning Costs- Preplanning costs include expenses incurred prior to construction related to initial project development, feasibility analysis, and early-stage planning activities. These costs reflect consulting, administrative coordination, and preliminary design considerations necessary to evaluate and initiate the proposed ASTC project. The clinical costs associated with this line item are \$13,566, which is .32% of the combined clinical construction, contingency, and equipment costs. This is reasonable and consistent with the scope and size of the project and meets the board's related financial criteria.

Site Survey and Soil Investigation- Site survey and soil investigation costs include expenses for boundary and topographic surveys, geotechnical borings, soil analysis, and environmental assessments necessary to evaluate site conditions prior to construction. These activities are required to confirm that the site can support the proposed facility and to inform foundation and grading design. The clinical costs associated with this line item are \$39,275, which is reasonable and proportionate to the scope of the project and meets the board's related financial criteria.

Site Preparation- Site preparation costs include grading, excavation, utility rough-ins, stormwater management, erosion control, and other work necessary to prepare the site for new construction. The clinical costs associated with this line item are \$105,000. Combined with Site Survey these costs represent 4.77% percent of clinical construction and contingency costs. The nonclinical site preparation costs of \$295,000 reflect the additional scope of work required for parking areas, landscaping, sidewalks, and other non-clinical site improvements. Total site preparation costs of \$400,000 are reasonable and consistent with the scope of work required for a project of this size in the suburban Chicago market and meets the board's related financial criteria.

New Construction Contracts- New construction costs represent the costs for all labor and materials required to build out the clinical and nonclinical space. The clinical costs are \$2,750,458, or \$509.34 per GSF based on 5,400 gross square feet of clinical space. These costs are consistent with industry standards for ambulatory surgical facilities and reflect current market conditions for construction in the Chicago metropolitan area. Nonclinical construction costs of \$2,528,154 cover the buildout of 4,551 gross square feet of nonclinical space, including administrative areas, waiting rooms, registration, and support functions. Total new construction costs are \$5,278,612 for a combined 9,951 gross square feet.

Contingencies- Contingency costs are included to account for unforeseen conditions or changes during construction, including material cost fluctuations, minor design modifications, or unexpected site conditions. The clinical contingency costs are \$275,000, representing approximately 9.93% of clinical construction costs, which is reasonable and consistent with a project of this scope and size and meets the board's related financial criteria.. Nonclinical contingency costs are \$275,000.

Architectural/Engineering Fees- Architectural and engineering fees include costs associated with the design, planning, and technical development of the facility. These services include preparation of construction drawings, engineering systems design (mechanical, electrical, plumbing), and compliance with applicable building codes and healthcare regulations. The clinical costs associated with this line item are \$260,000, representing approximately 8.59% of clinical construction and contingency costs. The amount is reasonable and proportionate to the size and complexity of the project and meets the board's related financial criteria.

Consulting and Other Fees- Consulting fees include costs for project management, regulatory consulting, legal support, and other professional services necessary to develop and implement the project. This includes assistance with the Certificate of Need application, permit fees, and compliance with regulatory requirements. The clinical costs for Consulting and Other Fees are \$488,393. Nonclinical consulting costs are \$411,607.

Consulting and Other Fees Breakdown:

- CON and Permit-Related Fees – \$55,000, costs associated with the preparation, filing, and support of the Certificate of Need application and related permit approvals.
- Project Management – \$250,000, professional project management services for oversight of design, construction, procurement, and regulatory milestones throughout the duration of the project.
- Landscape Design – \$45,000, professional landscape architecture services for site design, planting plans, and compliance with local zoning and aesthetic requirements.
- Interior Signage – \$35,000, design, fabrication, and installation of interior wayfinding, room identification, and regulatory signage throughout the facility.
- Civil Engineering – \$120,000, civil engineering services including site grading design, stormwater management, utility coordination, and site infrastructure design.
- Survey – \$20,000, professional land surveying services including boundary verification, as-built surveys, and construction staking.
- Traffic Study – \$15,000, traffic impact analysis required by the local municipality to assess the effect of the proposed facility on surrounding roadways and intersections.
- Agency Interaction – \$60,000, costs associated with interfacing with governmental and regulatory agencies, including the HFSRB, local building departments, fire marshals, and IDPH
- Interior Design – \$40,000, professional interior design services for clinical and nonclinical spaces, including material and finish selections, furniture layouts, and patient experience considerations.
- Process Improvement Consultant – \$30,000, consulting services for workflow optimization, patient flow analysis, and operational planning for the ambulatory surgical treatment center.
- Equipment Planning – \$40,000, professional equipment planning services including space and utility requirements, procurement coordination, and installation scheduling.
- Legal – \$90,000, legal services, regulatory compliance, corporate structuring, and other transactional matters associated with the project.
- Insurance – \$35,000, additional risk insurance and other project-related insurance coverage during the construction and pre-operational period.
- Systems Testing – \$25,000, testing and validation of building systems including HVAC, electrical, plumbing, medical gas, fire alarm, and life safety systems.
- Commissioning – \$40,000, third-party commissioning services to verify that all building systems are installed, calibrated, and operating in accordance with design specifications and applicable codes.

Movable or Other Equipment- Movable and other equipment costs include all clinical and nonclinical equipment necessary to support the operation of the proposed two-operating-room ambulatory surgical treatment center. Clinical costs amount to \$1,212,537, and that equipment includes, but is not limited to, surgical tables, anesthesia machines, patient monitoring systems, procedure lighting, imaging support equipment, and specialized instruments required for orthopedic, interventional pain management, and podiatric procedures. The equipment budget is further supported by the underlying construction scope, which includes significant investment in building systems necessary to operate a modern ambulatory surgical facility.

Nonclinical equipment costs of \$300,000 include administrative systems, information technology infrastructure, furnishings, and other operational equipment necessary to support patient registration, scheduling, medical records management, and overall facility operations. Total movable and other equipment costs are \$1,512,537.

Clinical Equipment List:

- Surgical Tables (2) – \$150,000, high-quality, multi-position surgical tables suitable for orthopedic and interventional procedures.
- Surgical Lights (2 sets) – \$90,000, ceiling-mounted LED surgical lighting systems for each operating room.

- Anesthesia Machines (2) – \$180,000, fully integrated anesthesia workstations with ventilators and monitoring capabilities.
- Patient Monitoring Systems (2) – \$75,000, multi-parameter monitors for intraoperative patient monitoring.
- C-Arm Fluoroscopy Unit (1) – \$195,000, mobile imaging system essential for interventional pain and minimally invasive orthopedic procedures.
- Ultrasound Unit (1) – \$55,000, used for guided injections and regional anesthesia.
- Autoclave / Sterilizer – \$45,000, for sterilization of surgical instruments.
- Instrument Washer / Disinfector – \$32,000, supports infection control and sterile processing workflow.
- Stretchers / Gurneys (4) – \$28,000, for patient transport between pre-op, OR, and recovery.
- PACU Monitoring Equipment (2 stations) – \$18,000, post-anesthesia care monitoring systems.
- Crash Cart & Emergency Equipment – \$12,000, includes defibrillator and emergency response supplies.
- Orthopedic Instrument Sets – \$65,000, comprehensive surgical instrument trays for orthopedic procedures.
- Pain Management Procedure Kits & Instruments – \$35,000, specialized kits for interventional pain management procedures.
- IV Poles, Mayo Stands, Back Tables, Equipment Stands – \$15,000, surgical support furniture and accessory stands.
- Video Integration & Documentation Systems (2) – \$48,000, high-definition video routing, recording, and display systems for each operating room.
- Electrosurgical Units (2) – \$30,000, bipolar and monopolar electrosurgical generators for each operating room.
- Surgical Instrument Tracking System – \$22,000, barcode-based tracking system for instrument sterilization and inventory management.
- Patient Warming Systems (2) – \$16,000, forced-air warming units to maintain normothermia during procedures.
- Pneumatic Tourniquets (2) – \$12,000, automated tourniquet systems for orthopedic extremity procedures.
- Medical Gas Equipment & Regulators – \$18,000, oxygen, nitrous oxide, and medical air delivery equipment and regulators.
- Pharmacy / Medication Storage & Dispensing – \$25,000, secure medication storage cabinets and dispensing systems.
- Sterile Processing Equipment & Storage – \$20,537, sterile supply storage systems, case carts, and processing area equipment.
- OR Furniture & Storage Systems – \$26,000, surgical cabinetry, supply storage, and operating room casework.

Net Interest Expense During Construction- The amount of \$341,875 in clinical net interest expense represents interest incurred on borrowed funds during the construction period prior to the facility becoming operational. Nonclinical net interest expense is \$288,125. Total net interest expense during construction is \$630,000. The estimate is based on the anticipated construction timeline and financing structure and is consistent with standard financial practices.

Fair Market Value of Leased Space or Equipment

This line item reflects the fair market value of leased space for the proposed addition of two operating as proposed for the Project.. The clinical fair market value is \$2,805,933, and the nonclinical fair market value is \$2,364,777, for a total of \$5,170,710. The valuation is based on commercially reasonable lease terms for comparable medical office and surgical space within the suburban Chicago market and ensures compliance with regulatory requirements regarding fair market value. The amount is based on a 10-year lease at an initial rate of \$48.55 per gross square foot for 9,951 gross square feet, with a 1.5% annual escalator. The year-by-year lease cost schedule is as follows:

Year	Rate per GSF	Annual Lease Cost
1	\$48.55	\$483,121.05
2	\$49.28	\$490,367.87
3	\$50.02	\$497,723.38
4	\$50.77	\$505,189.23
5	\$51.53	\$512,767.07
6	\$52.30	\$520,458.58
7	\$53.09	\$528,265.45
8	\$53.88	\$536,189.43
9	\$54.69	\$544,232.27
10	\$55.51	\$552,395.75
Total		\$5,170,710.08

Other Costs to Be Capitalized- Other costs to be capitalized include expenses that are required to bring the facility to operational readiness but are not included in other line items. The clinical costs associated with this line item are \$379,862 and nonclinical costs are \$320,138, for a total of \$700,000. These costs are reasonable and consistent with a project of this scope and size.

Other Costs to Be Capitalized Breakdown:

- Permits and Inspection Fees – \$85,000, costs for building permits, plan review fees, health department inspections, fire marshal inspections, and other governmental fees required to obtain occupancy and licensure.
- Insurance During Construction – \$65,000, builder's risk, general liability, and other insurance coverage required during the construction period to protect against loss or damage.
- Telecommunications and Data Infrastructure – \$95,000, installation of structured cabling, data network infrastructure, telephone systems, and wireless access points necessary for clinical and administrative operations.
- Exterior and Wayfinding Signage – \$55,000, design, fabrication, and installation of exterior building signage, directional signage, and ADA-compliant wayfinding elements.
- Furnishings (Waiting, Administrative, and Break Areas) – \$110,000, furnishings for patient waiting areas, reception, administrative offices, staff break room, and other nonclinical support spaces.
- HVAC Commissioning and Balancing – \$45,000, third-party testing, air balancing, and commissioning of heating, ventilation, and air conditioning systems to ensure compliance with healthcare ventilation standards and infection control requirements.
- IT Network Infrastructure and Cabling – \$75,000, server equipment, network switches, electronic health records system setup, and related information technology infrastructure.
- Medical Gas System Certification and Testing – \$30,000, third-party certification and testing of medical gas systems including oxygen, nitrous oxide, medical air, and vacuum systems in accordance with NFPA 99 standards.
- Fire Suppression and Life Safety Testing – \$25,000, inspection, testing, and certification of fire suppression, fire alarm, and life safety systems as required for healthcare occupancy.
- Utility Connection and Tap Fees – \$50,000, fees charged by local utility providers for connection to water, sewer, electric, and natural gas services.
- Miscellaneous Fees – \$65,000, other capitalized costs including as-built documentation, close-out costs, punch list management, and other expenses incidental to achieving operational readiness.

ATTACHMENT 8

Project Status and Completion Schedules

The proposed project involved construction and erection of a new building adjacent to the existing ASTC. The proposed project completion date is upon approval by the Illinois Department of Public Health of the facility to perform surgery on or by July 1, 2028.

Attachment 9 Cost Space Requirements

Dept. / Area	Cost	Gross Square Feet		Amount of Proposed Total Gross Square Feet That Is:			
		Existing	Proposed	New Const.	Modernized	As Is	Vacated Space
REVIEWABLE							
ASTC	\$8,728,362	-	5,400	5,400	-	-	-
Total Clinical	\$8,728,362	-	5,400	5,400	-	-	-
NON-REVIEWABLE							
Administrative	\$6,990,872	-	4,551	4,551	-	-	-
Total Non-clinical	\$6,990,872	-			-	-	-
TOTAL	\$15,719,234	-	9,551	9,551	-	-	-
APPEND DOCUMENTATION AS <u>ATTACHMENT 9</u> , IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.							

Attachment 11

Background of the Applicant

Orthollinois Surgery Center of Elgin, LLC

The proposed project is brought by Orthollinois Surgery Center of Elgin, LLC, an entity owned by physicians affiliated with Orthollinois. Orthollinois Surgery Center of Elgin, LLC is owned by in equal shares as reflected in Attachment 4.

No owner of Orthollinois Surgery Center of Elgin, LLC maintains an ownership interest in excess of 5% in any other healthcare facility, and thus can certify that there have been no adverse action during the three (3) years prior to the filing of this Application. A letter certifying to the above information is attached at Attachment 11.

We have included a letter authorizing access to the HFSRB and IDPH to verify information about Orthollinois Surgery Center of Elgin, LLC at Attachment 11.

Background of Orthollinois

This project is proposed by physicians affiliated with Orthollinois, a division of OrthoMidwest. Orthollinois is a leading bone and joint physician practice founded in 1967, with over 50 years of dedicated service to northern Illinois. The practice is comprised of more than 30 musculoskeletal subspecialty physicians and anesthesiologists spanning over a dozen clinical specialties. The practice employs between 501 and 1,000 individuals and provides exceptional care and expertise from six convenient clinic locations across northern Illinois, including locations in Rockford, Algonquin, Elgin, and McHenry, Illinois. Orthollinois serves patients throughout Winnebago, McHenry, and Kane counties.

Orthollinois' mission is "Partnering with people to promote and restore active lives." The practice is guided by its core values of Integrity, Respect, Accountability, Trust, Compassion, Empowerment, Education, and Innovation.

What sets Orthollinois apart is its commitment to subspecialized expertise. At Orthollinois, patients are not seen by a general orthopedist; they are cared for by a board-certified physician with subspecialty training focused on a specific area of the body. This focused expertise leads to more accurate diagnoses, innovative treatment plans, and ultimately, better outcomes. Orthollinois prides itself on delivering university-quality care through a one-stop, multi-specialty philosophy. This model allows patients the efficiency of diagnosis, clinical care, diagnostic imaging, and rehabilitation therapy from one location — all under the direction of board-certified physicians who have subspecialized in specific areas of orthopedic care including hand and elbow, hip and knee joint replacement, shoulder, spine and neck, sports medicine, trauma, pediatrics, foot and ankle, neurosurgery, rheumatology, physical medicine and rehabilitation, and occupational health. Orthollinois' physicians are board-certified and have subspecialized in their respective areas of expertise, with access to state-of-the-art technology and training to address each and every aspect of patient care.

Beyond its clinic locations, Orthollinois operates three Injury Express walk-in urgent care locations in Algonquin, Elgin, and Rockford, the only local injury walk-in facilities specializing in bones and joints and that are open seven days a week. The practice also operates multiple MRI imaging centers, nine rehabilitation locations, a durable medical equipment facility, and surgery centers in Rockford and Elgin, as well as the OrthoMidwest Surgery Center in Beloit, Wisconsin.

This expansion has required strong partnership with each of the community hospitals in which they serve, working collaboratively to offer the specialty care needed in cooperative relationships. Orthollinois physicians maintain privileges at multiple area hospitals, including OSF Saint Anthony Medical Center (Level I Trauma Center), Mercyhealth Javon Bea Hospital (Level I Trauma Center, Rockford), UW Health Northern Illinois/SwedishAmerican Hospital (Level II Trauma Center), Northwestern Medicine McHenry,

Huntley, and Woodstock Hospitals, Advocate Sherman Hospital, and Prime Healthcare Saint Joseph Hospital in Elgin. OrthoIllinois has been committed to exceptional patient care and meeting the orthopedic needs of the community throughout its period of consistent growth.

OrthoIllinois' surgery centers offer industry-leading care. In 2016, an OrthoIllinois surgeon performed one of the first outpatient total knee replacements in an ambulatory surgery center setting in the United States. Today, knee, hip, and shoulder replacements are common daily outpatient procedures performed at the centers, along with spine, arthroscopic, hand and upper extremity, and foot and ankle surgeries. OrthoIllinois Surgery Centers and OrthoMidwest Surgery Center are among a select few ambulatory surgery centers in the country to employ their own anesthesiologists, medical doctors devoted specifically to the ambulatory surgery centers, further ensuring the highest standards of patient safety.

The existing OrthoIllinois Surgery Centers are licensed and certified by the Illinois Department of Public Health, Medicare, and the Accreditation Association for Ambulatory Health Care (AAAHC). The Rockford surgery center has earned the additional recognition of the Association of periOperative Registered Nurses (AORN) Go Clear Award, designating it as a Center of Excellence in Surgical Safety: Smoke Evacuation. The OrthoMidwest Surgery Center is a Press Ganey Guardian of Excellence recipient. Additionally, the OrthoMidwest Surgery Center has been recognized as a 2026 Best Ambulatory Surgery Center in Wisconsin for orthopedic and spine surgery by U.S. News & World Report. The OrthoMidwest Surgery Center was designed specifically for joint replacement and spine surgeries and is equipped with an Intelligent Operating Room system that uses advanced technologies, including artificial intelligence capabilities, to optimize workflow and ensure precise and accurate implant positioning for more consistent surgical results.

Patients are viewed holistically with their individual needs driving treatment and surgical decisions. OrthoIllinois utilizes highly-skilled case managers to guide patients through preparation for surgery and post-surgery planning. Patients seek care with OrthoIllinois for all varieties of pain and injury, often for worsening conditions negatively impacting function and quality of life such as arthritis.

OrthoIllinois physicians are similarly dedicated to the medical education of students and residents and are affiliated with the University of Illinois College of Medicine as clinical assistant/associate professors, and the Rush University Medical Center Residency Program as site training facilitators. Advanced surgical technique is shared with other orthopedic specialists by OrthoIllinois physicians, who serve as guest instructors at national and international conferences and who host surgeons from around the globe to observe technique at the ambulatory surgery center and for hands-on training in the wet lab in Rockford. The practice also actively participates in national and international research studies through its dedicated Research Center, which was formalized in 2006. OrthoIllinois has executed over 100 clinical research and post-market studies over the years. The Research Center currently maintains multiple active clinical studies enrolling patients across specialties including rheumatology, shoulder surgery, and knee surgery, and employs a dedicated Director of Clinical Research and Clinical Research Coordinator. OrthoIllinois also collaborates with medical students and researchers at the University of Illinois College of Medicine at Rockford.

Furthering its commitment to surgical education and innovation, OrthoIllinois operates The Human Anatomy Lab Center, a state-of-the-art facility located at its Rockford campus. Established by the Midwest Foundation for Orthopaedic Research and Education (MFORE), a foundation created by OrthoIllinois physicians in 2009. The lab provides access to surgical training, research, and medical device product development for medical professionals and entrepreneurial-minded companies. The facility is equipped with five fully operational arthroscopic towers with video management systems, a fully operational operating room table for whole cadaver surgery, a large C-arm, cadaveric mounting and commercial tables for surgery simulation, battery-powered drills and saws, and comprehensive arthroscopic and open instrumentation sets. The Human Anatomy Lab Center also features state-of-the-art two-way audio and video conferencing technology that allows real-time surgical collaboration worldwide, enabling remote viewers to pan, tilt, and zoom cameras to observe procedures being performed in the lab. The facility includes dedicated freezer space for cadaveric specimen storage, a separate washroom and kitchen area for cleaning instrumentation, and adjacent meeting and dining areas. OrthoIllinois physicians regularly host surgeons from across the United States and around the globe including physicians from Korea,

Poland, India, Germany, Italy, Japan, and Canada for surgical observation and hands-on cadaveric training at this facility.

Press Ganey benchmarking for patient satisfaction with OrthoIllinois has consistently exceeded 95% for medical patient satisfaction and ranked in the 99th percentile nationally for "willingness to recommend." OrthoIllinois is recognized as a designated elite healthcare organization for highest levels of excellence in patient satisfaction and is featured in Castle Connolly Top Doctors listings. OrthoIllinois has demonstrated a deep commitment to the communities it serves, providing \$5.5 million in uncompensated care in 2019 and \$5.0 million in 2020. No patient will be denied services at the proposed facility because of their inability to pay.

Furthermore, OrthoIllinois has long been committed to community service and volunteerism as a core principle for the organization. Its physicians dedicate their time and financial support to many charitable organizations including the United Way, University of Illinois School of Medicine, and the Northern Illinois Food Bank after-school and weekend meal programs for children. OrthoIllinois has also earned recognitions for Best Sports Medicine/Orthopedic Clinic, Best Alternative Medicine, Best Urgent Care/Injury Express, Best Physical Therapy, Best Employer with 500+ Employees, and Best Overall Leadership.

In addition to its clinical services, OrthoIllinois operates a FitRight Precision Orthotic & Prosthetic Lab with over 65 years of combined practitioner experience, an Occupational Health Center (WorkRight program) serving employers and injured workers, a Run Right Running Clinic, rheumatology infusion services, and the JOYNT Program for joint replacement patients. OrthoIllinois also partners with HURT! to provide 24/7/365 access to acute orthopedic injury care through a telehealth platform, ensuring patients can receive specialist guidance at any time

Tom Stanley, M.D, M.P.H.

Dr. Tom Stanley, MD, MPH, FAAOS, is a distinguished orthopedic spine surgeon at OrthoIllinois, a division of OrthoMidwest, where he also serves as Vice President of OrthoMidwest. He is board certified by the American Board of Orthopaedic Surgery and is a Fellow of the American Academy of Orthopaedic Surgeons (FAAOS).

Driven by a lifelong fascination with biomechanics and the complexities of human function, Dr. Stanley's interest in how things are put together led him to pursue his undergraduate studies at Tulane University School of Engineering in New Orleans. He graduated with honors, earning a degree in Biomedical Engineering.

Following his undergraduate education, Dr. Stanley continued at Tulane University, where he earned both his Medical Doctorate and a Master of Public Health. His passion for biomechanics naturally aligned with the field of orthopedics, allowing him to address musculoskeletal problems and help patients return to normal function. He completed a five-year residency in orthopedic surgery at Rush University Medical Center in Chicago.

During his residency, Dr. Stanley developed a particular interest in treating pediatric scoliosis patients, which inspired him to subspecialize in orthopedic spine surgery. He then pursued advanced fellowship training in Orthopedic Spine Surgery at the Hospital for Joint Diseases at New York University Medical Center (now NYU Langone Orthopedic Hospital). There, he gained proficiency in minimally invasive surgical techniques for the neck and lower back.

Since 2010, Dr. Stanley has practiced as an orthopedic spine surgeon over 16 years of dedicated spine surgery experience initially in private practice in the northwest suburbs of Chicago. In 2018, he joined OrthoIllinois, where he continues to provide high-quality spine care to patients from the practice's Elgin and Algonquin locations. He maintains hospital affiliations with Advocate Sherman Hospital, Algonquin Road Surgery Center, Prime Healthcare Saint Joseph-Elgin, Mercyhealth Javon Bea Hospital, Northwestern Medicine McHenry/Huntley/Woodstock Hospitals, OSF Saint Anthony Medical Center, and

UW Health Northern Illinois/SwedishAmerican Hospital.

In his clinical practice, Dr. Stanley is committed to careful assessment of his patients' symptoms and treatment goals. He utilizes state-of-the-art diagnostic tools to identify the source of injury or condition, and develops comprehensive treatment plans aimed at helping patients achieve a more active, pain-free lifestyle. Whenever possible, he emphasizes conservative treatments such as injection therapy and physical rehabilitation. If surgery is required, Dr. Stanley specializes in the latest minimally invasive techniques, which reduce incision length, hospital stays, and recovery time. Dr. Stanley is also trained in the minimally invasive iFuse Implant System® from SI-Bone®, Inc., a medical device technology designed for the treatment of sacroiliac joint disorders.

Dr. Stanley has earned significant recognition for the quality of his clinical practice. He has been named a "Spine Surgeon Leader to Know" by Becker's Spine Review and has received Castle Connolly recognition for excellence in orthopedics. He has authored 4 publications with over 500 citations in the medical literature. Dr. Stanley maintains a 4.8 out of 5.0 patient satisfaction rating based on over 1,300 patient ratings, reflecting his dedication to individualized patient care and clinical excellence.

Attachment 11

Background of the Applicant

Tom Stanley, M.D., M.P.H.

650 S. Randall Rd
Algonquin, IL 60102
tomdstanley@gmail.com

Employment

2018 - Current	OrthoIllinois 650 S. Randall Rd Algonquin, IL 60102
2010 - 2018	Midwest Bone and Joint 2350 Royal Blvd, Suite 200 Elgin, IL 60123

Hospital/Surgery Center Privileges

Full Medical Staff

Advocate Sherman Hospital Elgin, IL
Presence St. Joseph Hospital Elgin, IL
Northwestern Huntley Hospital Huntley, IL
Northwestern McHenry Hospital McHenry, IL
Ascension St. Alexius Hospital Hoffman Estates, IL

Academic Appointments

2023 - Present	University of Illinois at Chicago, College of Medicine Rockford
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Attachment 11

Background of the Applicant

Clinical Assistant Professor

Education

2009 – 2010	Hospital for Joint Diseases New York University Medical Center New York, NY Fellowship in Orthopedic Spine Surgery
2004 – 2009	Rush University Medical Center Chicago, IL Residency in Orthopedic Surgery
2000 – 2004	Tulane University, School of Medicine New Orleans, LA M.D.
2000 – 2004	Tulane University, School of Medicine New Orleans, LA M.P.H. in Health Systems Management
1996 – 2000	Tulane University, School of Engineering B.S.E. in Biomedical Engineering Honors in Biomedical Engineering

Certifications

Fellow of the American Academy of Orthopedic Surgeons – 2013, current
American Board of Orthopedic Surgery Part I – Passed in July, 2009
American Board of Orthopedic Surgery Part II – Passed in July, 2012
American Academy of Disability Evaluating Physicians CEDIR (Certification in the Evaluation of Disability and Impairment Rating) – Passed January 2013

Publications

Singh K, Dumonski M, Stanley T, Phillips F. Repeat use of rhBMP-2 at an Adjacent Lumbar Level: An Assessment of Efficacy and Immunologic Response. *Spine*. 2011 Feb 1;36(3): 192-196.

Lee MJ, Dumonski M, Cahill P, Stanley T, Park D, Singh K. Percutaneous treatment of vertebral compression fractures: a meta-analysis of complications. *Spine*. 2009 May 15;34(11):1228-32.

Attachment 11

Background of the Applicant

DeWald CJ, Stanley T. Instrumentation-related complications of multilevel fusions for adult spinal deformity patients over age 65: surgical considerations and treatment options in patients with poor bone quality. *Spine*. 2006 Sep 1;31(19 Suppl):S144-51.

Barrack RL, Stanley T, Burt M, Hopkins S. The effect of stem design on end-of-stem pain in revision total knee arthroplasty. *J Arthroplasty*. 2004 Oct;19(7 Suppl 2):119-24.

Cook SD, Salkeld SL, Stanley T, Faciane A, Miller SD. Biomechanical study of pedicle screw fixation in severely osteoporotic bone. *Spine J*. 2004 Jul-Aug;4(4):402-8.

Barrack RL, Stanley T, Butler AR. Treating extensor mechanism disruption after total knee arthroplasty. *Clin Orthop Relat Res*. 2003 Nov;(416):98-104.

Book Chapters

Stanley T, Lee M, Dumonski M, Singh K. Posterior Thoracic and Lumbar Approaches. *Operative Techniques in Spine Surgery*. Edited by Rhee J, Boden S, Flynn J. LWW 2013.

Dumonski M, Stanley T, Lee M, Wojewnik B, Singh K. Posterolateral Thoracolumbar Fusion with Instrumentation. *Operative Techniques in Spine Surgery*. Edited by Rhee J, Boden S, Flynn J. LWW 2013.

Spivak J, Stanley T, Balderston R. Lumbar Total Disc Replacement. *Rothman-Simeone The Spine*, 6th Edition. Edited by Herkowitz H, Garfin S, Eisomont F, Bell G, Balderston R. Elsevier. 2011.

Stanley T, Wojewnik B, Vaccaro A, Singh K. Spinal Cord Injury: Rehabilitation and Recovery. *Neurotrauma and Critical Care of the Spine*, Edited by Jack Jallo, MD, and Alexander R. Vaccaro, MD. Thieme, New York, September 2008.

Stanley T, Dumonski M, Lee M, Singh K. Basic Approaches: Posterior Thoracic and Lumbar. *Operative Techniques in Orthopedics*. Lippincott Williams & Wilkins. Edited by John Rhee, MD, Scott Boden, MD. Lippincott Williams & Wilkins. 2007.

Lee M, Dumonski M, Stanley T, Singh K. Iliac Crest Bone Graft Harvest. In Weisel S (Ed.), *Operative Techniques in Orthopaedic*. Lippincott Williams & Wilkins. 2007.

Dumonski M, Stanley T, Lee M, Wojewnik B, Singh K. Posterolateral Thoracolumbar Fusion with Instrumentation. *Operative Techniques in Orthopedics*. Lippincott Williams & Wilkins. Edited by John Rhee, MD, Scott Boden, MD. Lippincott Williams & Wilkins. 2007.

Attachment 11

Background of the Applicant

Presentations

Stanley T, Singh K, Dumonski M, Phillips F. Repeat use of rhBMP-2 at an Adjacent Lumbar Level: An Assessment of Efficacy and Immunologic Response. Presented at the North American Spine Society Meeting, Toronto, Canada, October 2008.

Hospital Positions

2016 - Ongoing	Committee Member, Sherman Hospital Surgical Steering Committee
2020 - 2022	Vice Chairman of Surgery, Sherman Hospital

Awards/ Honors

Advocate Physician Quality of Care Award 2019
Advocate Patient Engagement Award 2018
Advocate Physician Quality of Care Award 2015
Advocate Physician Communications Award 2014
Sherman Hospital Patient Care Award 2013
NYU/HJD Fellow Research Award 2010
Rush University Senior Research Award 2009
Caldwell Society Award for Excellence in Orthopedics 2004
Tulane Medical School Merit Scholarship 2000-2004
Tulane School of Public Health Merit Scholarship 2000-2004
National Institutes of Health Research Fellow 1999

Attachment 12

Purpose of the Project

Orthollinois Surgery Center Elgin, LLC ("Orthollinois") is proposing to expand its existing ambulatory surgical treatment center ("ASTC") located at 2440 Alft Lane in Elgin, Illinois through the addition of two operating rooms. The proposed project is intended to increase the facility's capacity to provide outpatient orthopedic surgery, podiatric surgery, and pain management procedures to residents of the Elgin market area and surrounding communities. The expansion will bring the facility from four to six total operating rooms, increasing annual available procedure hours from approximately 7,500 to 11,250 hours. This expansion will allow Orthollinois to meet growing demand for outpatient surgical services while continuing to provide care in a high-quality, patient-centered environment.

The market area served by the facility is located within Health Service Area 8 ("HSA 8"), Health Planning Area A-11, which encompasses Kane County and portions of McHenry County. The primary service area includes residents of Elgin and the surrounding communities who currently utilize the facility for orthopedic and musculoskeletal care. Analysis of current patient data demonstrates that the facility serves patients from a broad geographic area, with patients originating from ZIP codes across the 60014, 60021, 60050, 60051, 60081, 60098, 60110, 60118, 60120, 60123, 60124, 60136, 60140, 60142, 60152, 60156, 60177, 60184, 60188, and 60193 ranges, among others. This geographic distribution reflects the facility's role as a regional destination for orthopedic and musculoskeletal surgical care within HSA 8 and the broader northwest suburban Chicago corridor.

Several interrelated issues in the market area support the need for this expansion. The most pressing issue facing the facility is that current surgical demand exceeds the capacity of its existing four operating rooms. During the trailing twelve-month period from July 2025 through June 2026, Orthollinois physicians performed a total of 7,105 surgical procedures across all settings, including 3,939 procedures in ambulatory surgery centers, 2,901 procedures in hospital settings, and 265 office-based procedures. Of the ASC-based procedures, 3,860 cases were performed at Orthollinois Surgery Center Elgin.

Monthly case volumes at ASTC remained consistently high throughout the period, ranging from 293 to 389 cases per month, averaging approximately 328 cases per month. Based on actual operating room time data the facility currently requires approximately 6 operating rooms to accommodate its existing case volume. Absent the proposed expansion, the facility will be unable to accommodate projected case volumes, and patients will increasingly face delays in scheduling or be diverted to higher-cost hospital settings.

Advances in surgical techniques, anesthesia, postoperative pain management, and patient selection protocols have resulted in a substantial migration of orthopedic, podiatric, and pain management procedures from inpatient hospital settings to outpatient environments. Numerous studies have demonstrated that appropriately selected patients can safely undergo these procedures in ambulatory surgery centers while achieving outcomes comparable to those achieved in hospital outpatient departments.

Orthollinois physicians maintain strong collaborative relationships with area hospitals, including Advocate Sherman Hospital, Northwestern Medicine Huntley, and Prime Healthcare Saint Joseph Hospital, and will continue to perform a substantial volume of procedures at those facilities. During the trailing twelve-month period, 2,901 procedures were performed at area hospitals, reflecting the continued importance of hospital-based care for medically complex patients and procedures requiring additional support services. The proposed expansion is not intended to shift existing hospital volumes but rather to accommodate the organic growth in new outpatient surgical cases that are increasingly appropriate for the ambulatory setting. As total surgical demand continues to grow, the additional operating room capacity will allow Orthollinois to absorb incremental volume in the ASC environment without adversely impacting its hospital partners.

The project also addresses the need for affordable healthcare services within the market area. As new surgical volume grows, providing access to care in a cost-effective ambulatory setting benefits patients and the healthcare system. Research consistently demonstrates that ambulatory surgery centers provide significant cost savings compared to hospital outpatient departments. In a study evaluating sixty-two common sports medicine procedures, procedures performed in ambulatory surgery centers resulted in substantially lower total costs, facility fees, Medicare expenditures, and patient out-of-pocket expenses than identical procedures performed in hospital outpatient departments. Across all procedures studied, total costs were approximately 40% lower and patient payments were approximately 37% lower when services were provided in an ambulatory surgery center setting.

In addition to reducing costs for orthopedic patients, ambulatory surgery centers have demonstrated substantial economic benefits for spine procedures. A recent study of 771 patients undergoing lumbar decompression surgery found that patients treated in ambulatory surgery centers experienced significantly lower initial surgical costs and lower total one-year episode-of-care costs while maintaining similar complication rates and clinical outcomes. The study concluded that ambulatory surgery centers provide a safe and cost-effective environment for appropriately selected lumbar spine patients and generated total one-year costs that were substantially lower than hospital outpatient settings.

These cost savings are particularly important for the population served by the ASTC, where Medicare patients represent the facility's largest payor group. During the trailing twelve-month period, the facility's payor mix was as follows:

Payor Name	% of Patients Treated at Facility
Private Insurance	46%
Medicare	45%
Medicaid	2.5%
Self-Pay	2%
Worker's Compensation	4.5%

With nearly 45% of patients covered by Medicare, the cost differential between hospital outpatient departments and ambulatory surgery centers translates directly into reduced Medicare expenditures and lower out-of-pocket costs for beneficiaries. The proposed expansion will allow a greater number of Medicare and other patients to receive care in the lower-cost ASC setting.

The proposed project will also improve patient access to outpatient spine services. The expansion will allow Orthollinois to accommodate increasing demand for outpatient cervical and lumbar procedures that are now commonly performed on a same-day basis. A large multicenter study comparing ambulatory surgery centers and hospital outpatient departments found that patients undergoing anterior cervical discectomy and fusion, cervical disc arthroplasty, and lumbar decompression experienced similar patient-reported outcomes and return-to-work rates regardless of whether surgery occurred in an ambulatory surgery center or hospital outpatient department. The study concluded that outpatient spine surgery can be performed safely and effectively in both settings, supporting the continued migration of appropriate procedures into ambulatory environments.

During the last 12-month period, Orthollinois spine surgeons performed procedures at the Elgin facility including lumbar laminotomies, cervical disc arthroplasty, spinal cord stimulator implantation, and other spinal procedures. The additional operating room capacity will enable the facility to accommodate the anticipated continued growth in outpatient spine cases.

The project will further improve patient convenience and experience by expanding access to care in a setting specifically designed for outpatient surgery. Ambulatory surgery centers generally offer

streamlined care processes, shorter lengths of stay, efficient scheduling, and faster discharge times than hospital-based settings. Literature evaluating outpatient orthopedic and spine surgery has found that ambulatory surgery centers can provide high-quality outcomes while reducing unnecessary healthcare utilization and improving operational efficiency. These characteristics are particularly important for working-age adults and Medicare beneficiaries seeking timely access to surgical care closer to home.

Through these goals and measurable objectives, the proposed project will improve healthcare accessibility, affordability, and efficiency for residents of the Elgin service area and the broader HSA 8

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Original Research

Cost Comparison of Sports Medicine Procedures in Ambulatory Surgery Centers Versus Hospital Outpatient Departments for Medicare Recipients

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Background: Healthcare costs in the United States are rising in conjunction with an increased utilization of outpatient centers, particularly in sports medicine.

Purpose/Hypothesis: The primary purpose of this study was to utilize Medicare data to compare the overall cost of sports medicine procedures performed in the ambulatory surgery centers (ASCs) and hospital outpatient department (HOPD) settings. The secondary purpose of this study was to compare facility fees, surgeon fees, Medicare payments, and patient payments between ASCs and HOPDs. It was hypothesized that procedures performed at ASCs would demonstrate a lower overall cost than those performed at HOPDs.

Study Design: Cross-sectional study.

Methods: Publicly available data from the Centers for Medicare & Medicaid Services (CMS) were accessed via the Medicare Procedure Price Lookup Tool. Current Procedural Terminology (CPT) codes were used to identify sports medicine procedures approved for the outpatient setting by CMS. Facility fees, surgeon fees, total costs, Medicare payments, and patient payments were extracted. Descriptive statistics were utilized to calculate the mean and standard deviation for each category of fee and payment.

Results: A total of 62 CPT codes were identified. Compared with HOPDs, shoulder procedures ($n = 25$) at ASCs had lower total costs ($\$3622 \pm \1160 vs $\$6261 \pm \1759 ; $P < .001$), facility fees ($\$2777 \pm \1020 vs $\$5416 \pm \1606 ; $P < .001$), Medicare payments ($\$2898 \pm \928 vs $\$5009 \pm \1407 ; $P < .001$), and patient payments ($\$724 \pm \232 vs $\$1252 \pm \352 ; $P < .001$) compared with HOPDs. Knee procedures ($n = 31$) at ASCs had lower total costs ($\$4236 \pm \2741 vs $\$6668 \pm \3341 ; $P = .006$), facility fees ($\$3408 \pm \2507 vs $\$5840 \pm \3116 ; $P = .006$), Medicare payments ($\$3389 \pm \2193 vs $\$5458 \pm \2955 ; $P = .006$), and patient payments ($\$847 \pm \548 vs $\$1209 \pm \429 ; $P = .011$). Hip procedures ($n = 6$) at ASCs had lower total costs ($\$3583 \pm \698 vs $\$6671 \pm \1451 ; $P = .025$), facility fees ($\$2725 \pm \669 vs $\$5813 \pm \1431 ; $P = .025$), Medicare payments ($\$2866 \pm \558 vs $\$5336 \pm \1161 ; $P = .025$), and patient payments ($\$716 \pm \139 vs $\$1333 \pm \290 ; $P = .025$) compared with HOPDs.

Conclusion: Our study demonstrates that sports medicine procedures performed at ASCs for Medicare recipients result in considerable overall total cost savings when compared with those performed at HOPDs. Sports medicine providers should be aware of differences in costs when determining the best setting for these procedures.

Keywords: ambulatory surgery center; cost; Medicare; outpatient surgery; savings; sports medicine

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Healthcare costs in the United States are on the rise and are expected to continue increasing. The national health expenditure grew 2.7% in 2021 to \$4.3 trillion. The Centers for Medicare & Medicaid Services (CMS) expects this number to rise by 5.4% annually through 2028, which amounts to nearly \$13,000 per person, of which 21% is secondary to Medicare spending.²⁰ Given these expenditures, government insurance providers are continuously looking for ways to save money for both the institution and patients. This downward pressure has resulted in decreasing Medicare reimbursement for orthopaedic surgeons and facilities.^{9,21}

Partly as a result of this financial stress, there has been an increasing proportion of orthopaedic surgeries being performed on an outpatient basis.^{2,7} Outpatient facilities consist of both hospital outpatient departments (HOPDs) and ambulatory surgery centers (ASCs). HOPDs are facilities owned and attached to a hospital, while ASCs are standalone facilities.²² ASCs have been shown in the literature to not only provide cost savings compared with HOPDs but also to be safe and effective for many common orthopaedic procedures.^{3,11,22,24,25,30} It has been postulated that competition between ASCs and HOPDs is beneficial in controlling and reducing costs to the healthcare system.⁴ A 2022 study by Wang et al³² investigated trends in ASC and HOPD usage and surgical costs for 6 of the most common orthopaedic procedures from 2013 to 2018. The authors found that ASC utilization increased by 3% while total costs decreased by 0.1% yearly. During the same period, costs at HOPDs increased by 2.5% yearly, with the mean total costs 26% higher than those at ASCs.³² Our group previously showed that shoulder and elbow procedures performed at ASCs resulted in cost savings when compared with HOPDs.¹¹ However, no studies to this point have looked more broadly at all of the most common sports medicine procedures.

The primary purpose of this study was to utilize Medicare data to compare the overall cost of sports medicine procedures performed at ASCs and HOPDs. In addition, this study aimed to compare facility fees, surgeon fees, Medicare payments, and patient payments between these 2 settings. We hypothesized that procedures performed at ASCs would demonstrate a lower overall cost than those performed at HOPDs.

METHODS

Data Collection

Medicare publishes publicly available data on an annual basis that details volume, reimbursement rates, and costs for medical procedures. This database has been utilized in orthopaedic literature for a variety of studies.^{1,11,13,17,18,21,28} For this study, the Medicare Procedure Price Lookup Tool³⁰ was queried using individual Current Procedural Terminology (CPT) codes for sports medicine procedures approved for outpatient surgery by the CMS. The American Board of Orthopaedic Surgeons sports medicine subspecialty case list was used to identify common sports medicine CPT codes.⁶ Details on which CPT codes were included can be found in the appendix. Procedures were categorized based on anatomic region. These categories included shoulder, knee, hip, and combined cohorts. Data on the total cost, facility fees, surgeon fees, Medicare payments, and patient payments for each procedure were collected. The total cost is equal to the facility fee plus the surgeon's fee. The Medicare payment is reported as 80% of the total cost, and the remaining amount is the patient's payment.³¹ These costs were compared between ASCs and HOPDs.

Statistical Analysis

Descriptive statistics were utilized to calculate the mean and standard deviation for each category of fee and payment. Differences in costs between ASCs and HOPDs for shoulder, knee, and hip procedures were included. An analysis of all procedures combined was also conducted. Total costs, facility fees, surgeon fees, Medicare payments, and patient payments were all analyzed. The means of each type of fee were calculated and compared between ASCs and HOPDs to assess mean savings. The Mann-Whitney *U* test was utilized, given the nonparametric distribution of the data. All statistical analysis was performed using Stata Version 17.0 (StataCorp). All tests were 2-sided, with statistical significance set at a probability value of $P < .05$.

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Ethical approval was not sought for the present study.

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TABLE 1
Costs Associated With ASCs and HOPDs for Shoulder,
Knee, Hip, and Combined Cohorts^a

	ASC	HOPD	^b P
Shoulder			
Total cost	3622 ± 1160	6261 ± 1759	<.001
Doctor fee	846 ± 216	846 ± 216	≥.999
Facility fee	2777 ± 1020	5416 ± 1606	<.001
Medicare payment	2898 ± 928	5009 ± 1407	<.001
Patient payment	724 ± 232	1252 ± 352	<.001
Knee			
Total cost	4236 ± 2741	6668 ± 3341	.006
Doctor fee	828 ± 291	828 ± 291	≥.999
Facility fee	3408 ± 2507	5840 ± 3116	.006
Medicare payment	3389 ± 2193	5458 ± 2955	.006
Patient payment	847 ± 548	1209 ± 429	.011
Hip			
Total cost	3583 ± 698	6671 ± 1451	.025
Doctor fee	858 ± 155	858 ± 155	≥.999
Facility fee	2725 ± 609	5813 ± 1431	.025
Medicare payment	2866 ± 558	5336 ± 1161	.025
Patient payment	716 ± 139	1333 ± 290	.025
Combined			
Total cost	3926 ± 2089	6504 ± 2631	<.001
Doctor fee	838 ± 249	838 ± 249	≥.999
Facility fee	3088 ± 1909	5666 ± 2450	<.001
Medicare payment	3140 ± 1671	5265 ± 2287	<.001
Patient payment	784 ± 418	1238 ± 384	.002

^aValues are presented in US\$ as mean ± SD. Bold *P* values indicate statistical significance (*P* < .05). ASC, ambulatory surgical center; HOPD, hospital outpatient department.

^b*P* values calculated using the Mann-Whitney *U* test.

RESULTS

Shoulder Codes

In this study, 25 of the most commonly utilized CPT codes were included (See Appendix). ASCs demonstrated lower cost of procedure (\$3622 ± \$1160 vs \$6261 ± \$1759; *P* < .001), facility fees (\$2777 ± \$1020 vs \$5416 ± \$1606; *P* < .001), Medicare payments (\$2898 ± \$928 vs \$5009 ± \$1407; *P* < .001), and patient payments (\$724 ± \$232 vs \$1252 ± \$352; *P* < .001) compared with HOPDs (Table 1). Compared with procedures performed at HOPDs, those performed at ASCs showed a 42% reduction in total costs, Medicare payments, and patient payments. They also demonstrated a 49% cost saving for facility fees. Surgeon fees were the same regardless of the surgery setting.

Knee Codes

For this study, 31 of the most commonly utilized knee CPT codes were identified (see Appendix). ASCs demonstrated lower total costs (\$4236 ± \$2741 vs \$6668 ± \$3341; *P* = .006), facility fees (\$3408 ± \$2507 vs \$5840 ± \$3116; *P* = .006), Medicare payments (\$3389 ± \$2193 vs \$5458 ± \$2955; *P* = .006), and patient payments (\$847 ± \$548 vs

\$1209 ± \$429; *P* = .011) (Table 1). ASCs had 36% lower total costs, a 42% lower facility fee, 38% lower Medicare payments, and 30% lower patient payments. Surgeon fees were the same regardless of the surgery setting.

Hip Codes

When comparing the 6 most common hip CPT codes (See Appendix), ASCs showed significant cost savings in the total procedure cost (\$3583 ± \$698 vs \$6671 ± \$1451; *P* = .025), facility fees (\$2725 ± \$609 vs \$5813 ± \$1431; *P* = .025), Medicare payments (\$2866 ± \$558 vs \$5336 ± \$1161; *P* = .025), and patient payments (\$716 ± \$139 vs \$1333 ± \$290; *P* = .025) (Table 1). This amounted to approximately 46% cost savings for total costs, Medicare payments, and patient payments, as well as 53% for facility fees. Surgeon fees were the same regardless of the surgery setting.

Combined Sports Medicine Procedures

When all 62 procedural codes were combined into a single cohort, ASCs once again had lower costs across all variables outside of surgeon fees. The total cost (\$3926 ± \$2089 vs \$6504 ± \$2631; *P* < .001), facility fees (\$3088 ± \$1909 vs \$5666 ± \$2450; *P* < .001), Medicare payments (\$3140 ± \$1671 vs \$5265 ± \$2287; *P* < .001), and patient payments (\$784 ± \$418 vs \$1238 ± \$384; *P* = .0024) were all significantly lower if performed at an ASC (Figure 1). On average, total costs and Medicare payments were 40% lower, facility fees were 45% lower, and patient payments were 37% lower when procedures were performed at ASCs.

DISCUSSION

The major findings of this study were that shoulder, knee, and hip sports medicine procedures all have a lower mean total cost when performed at ASCs compared with HOPDs. In addition, ASCs had lower facility fees, Medicare payments, and patient payments for all cohorts. This study also revealed that Medicare payments typically fully covered the facility fee for procedures performed at ASCs, whereas Medicare payments were consistently lower than the higher facility fee of HOPDs. The surgeon's fees were equivalent for all procedures, regardless of site. As the emphasis on cost-conscious healthcare spending grows, reducing extraneous costs while maintaining optimal outcomes is the goal. The present study sought to investigate differences in the cost to Medicare beneficiaries between ASCs and HOPDs for sports medicine procedures.

Medicare expenditures continue to rise yearly, and the results of this study suggest that transitioning care to ASCs from HOPDs when medically appropriate results in a mean total cost savings of 42% for shoulder procedures, 36% for knee procedures, and 46% for hip procedures. Our findings are in line with those of Wang et al,³² who

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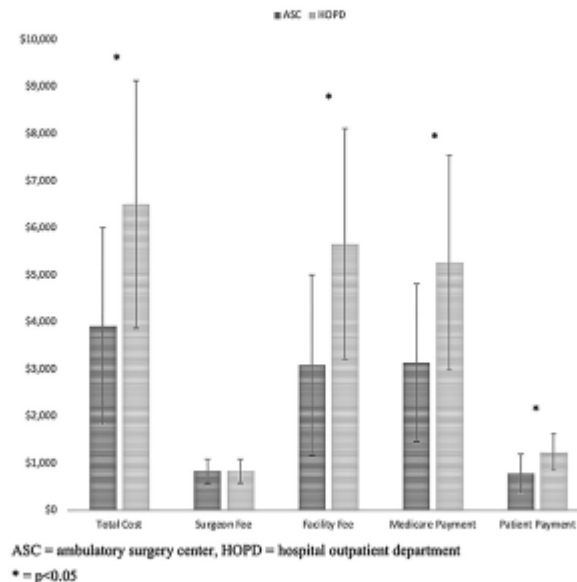


Figure 1. Cost breakdown for the combined sports medicine cohort (shoulder, knee, and hip), comparing ambulatory surgery centers and hospital outpatient departments.

found a 26% decrease in cost for procedures done at ASCs compared with HOPDs in a cohort from 2013 from 2018. These procedures included carpal tunnel release, lumbar microdiscectomy, anterior cruciate ligament reconstruction (ACLR), knee arthroscopy, arthroscopic rotator cuff repair, and bunion repair. The present study indicates that the cost-savings gap between facilities may potentially be widening. The reasons behind ASC cost savings are multifactorial but are theorized to lower overhead costs, reduced inventory, narrower scope of practice, faster operating room turnover, decreased postoperative resource utilization, and fewer staff.^{8,10} The lower expense of ASCs puts market pressure on HOPDs to reduce costs and streamline care, ultimately resulting in lower costs to insurance and the patient. Lopez et al²⁵ found an 8.8% increase in annual procedure volume in a Medicare population at ASCs, with a 10.5% increase in reimbursement per case at these sites from 2012 to 2017. In 2019, CMS updated reimbursement modalities for both facilities to move toward site-neutrality in cost, although they estimated that most changes were expected to be a reduction in HOPD costs.⁸ ASCs have also been shown in the literature to be as safe as HOPDs with equivalent low complication rates for procedures such as hip arthroscopy, ACLR, shoulder surgery, and others across orthopaedic subspecialties.²³⁻²⁶ Physician ownership in ASCs has certainly played a role in the movement of cases away from HOPDs. Physicians who own a stake in an ASC ultimately garner

a portion of the revenue the facility generates. Thus, there is a financial incentive to bring cases to their ASC instead of an HOPD.

Procedures performed at HOPDs were also associated with a mean increase of \$400 to \$500 in patient payments compared with ASCs. As the surgeon's fees were equal between sites for all procedures, this does not explain the observed increase. The higher patient payment appears to stem from the higher facility fees at HOPDs compared with ASCs. Facility fees were consistently higher at HOPDs, and while Medicare payments were also higher at these sites, they generally did not fully cover the increased facility fee. This led to a mean cost increase of nearly \$450 to the patient when a procedure was performed in an HOPD compared with an ASC, amounting to 30% to 46% higher out-of-pocket expenses to the patients for the same procedure. Schoen et al²⁶ in 2017 found that ~one-fourth of Medicare recipients pay ≥20% of their income on insurance premiums and medical care. Therefore, these savings provided by ASCs are especially valuable to Medicare beneficiaries who already have costly medical bills on top of traditionally lower or fixed incomes. To our knowledge, this study is the first assessment of the differential patient payments between HOPDs and ASCs for these sports medicine procedures.

Not all patients are candidates for outpatient surgery at an ASC. At HOPDs, surgeons are more equipped to care for patients with greater medical complexity, given access to

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medical specialists and the ability to admit patients who require extended observation. This has led to an environment where older, sicker patients are more likely to undergo surgery at HOPDs than ASCs. Differences in cost may reflect an attempt by HOPDs to recoup the cost of caring for these more complex patients to remain solvent. When selecting appropriate patients for outpatient success, orthopaedic sports medicine providers need to consider patient factors—including medical comorbidities and social circumstances.^{19,22,33}

Limitations

Limitations of this study pertain to the usage of publicly available Medicare data provided by the CMS. The validity of this data is based on proper CPT coding by surgeons and ongoing database maintenance. In addition, the database estimates the cost for individual CPT codes, whereas oftentimes orthopaedic sports medicine procedures include multiple CPT codes being billed, given the diverse nature of the specialty. We attempted to control for this by including all available outpatient CPT codes pertaining to sports medicine procedures in the shoulder, hip, and knee. This is a study of Medicare payors only, which is particularly important as relatively few patients undergoing sports medicine procedures have Medicare as their primary insurance. Yet the results may inform general payment trends that can be extrapolated to other medical payors. Future studies should evaluate the cost differences for various payer mixes apart from Medicare.

CONCLUSION

Our study demonstrates that sports medicine procedures performed at ASCs for Medicare recipients result in considerable overall total cost savings when compared with those performed at HOPDs. Sports medicine providers should be aware of differences in costs when determining the best setting for these procedures.

Supplemental Material for this article is available at <https://journals.sagepub.com/doi/full/10.1177/23259671251333110#supplementary-materials>.

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Outpatient versus inpatient lumbar decompression surgery: a matched noninferiority study investigating clinical and patient-reported outcomes

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OBJECTIVE Spine surgery represents an ideal target for healthcare cost reduction efforts, with outpatient surgery resulting in significant cost savings. With an increased focus on value-based healthcare delivery, lumbar decompression surgery has been increasingly performed in the outpatient setting when appropriate. The aim of this study was to compare clinical and patient-reported outcomes following outpatient and inpatient lumbar decompression surgery.

METHODS The Quality Outcomes Database (QOD) was queried for patients undergoing elective one- or two-level lumbar decompression (laminectomy or laminotomy with or without discectomy) for degenerative spine disease. Patients were grouped as outpatient if they had a length of stay (LOS) < 24 hours and as inpatient if they stayed in the hospital ≥ 24 hours. Patients with ≥ 72-hour stay were excluded from the comparative analysis to increase baseline comparability between the two groups. To create two highly homogeneous groups, optimal matching was performed at a 1:1 ratio between the two groups on 38 baseline variables, including demographics, comorbidities, symptoms, patient-reported scores, indications, and operative details. Outcomes of interest were readmissions and reoperations at 30 days and 3 months after surgery, overall satisfaction, and decrease in Oswestry Disability Index (ODI), back pain, and leg pain at 3 months after surgery. Satisfaction was defined as a score of 1 or 2 in the North American Spine Society patient satisfaction index. Noninferiority of outpatient compared with inpatient surgery was defined as risk difference of < 1.5% at a one-sided 97.5% confidence interval.

RESULTS A total of 18,689 eligible one- and two-level decompression surgeries were identified. The matched study cohorts consisted of 5016 patients in each group. Nonroutine discharge was slightly less common in the outpatient group (0.6% vs 0.3%, $p = 0.01$). The 30-day readmission rates were 4.4% and 4.3% for the outpatient and inpatient groups, respectively, while the 30-day reoperation rates were 1.4% and 1.5%. The 3-month readmission rates were 6.3% for both groups, and the 3-month reoperation rates were 3.1% for the outpatient cases and 2.9% for the inpatient cases. Overall satisfaction at 3 months was 88.8% for the outpatient group and 88.4% for the inpatient group. Noninferiority of outpatient surgery was documented for readmissions, reoperations, and patient-reported satisfaction from surgery.

CONCLUSIONS Outpatient lumbar decompression surgery demonstrated slightly lower nonroutine discharge rates in comparison with inpatient surgery. Noninferiority in clinical outcomes at 30 days and 3 months after surgery was docu-

ABBREVIATIONS ASA = American Society of Anesthesiologists; ASC = ambulatory surgical center; CAD = coronary artery disease; COPD = chronic obstructive pulmonary disease; LOS = length of stay; MCID = minimal clinically important difference; NASS = North American Spine Society; NRS = numeric rating scale; ODI = Oswestry Disability Index; PRO = patient-reported outcome; QOD = Quality Outcomes Database; SMD = standardized mean difference.

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mented for outpatient compared with inpatient decompression surgery. Additionally, outpatient decompression surgery performed noninferiorly to inpatient surgery in achieving patient satisfaction from surgery.

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KEYWORDS lumbar decompression; outpatient surgery; Quality Outcomes Database; readmissions; reoperations; patient-reported outcomes; noninferiority analysis

LUMBAR decompression surgery, defined as laminectomy or laminotomy with or without discectomy, is one of the most common spinal procedures, and it is performed to address several spinal pathologies, such as lumbar stenosis and disc herniation.^{1,2} Traditionally, the procedure has required a 1- to 2-day inpatient hospital stay; however, due to an increased focus on value-based healthcare, this procedure has been increasingly performed in the outpatient setting when appropriate.

It was estimated that approximately \$34 billion was spent in 2010 alone diagnosing and treating spine problems.³ Efforts to reduce the cost of spine surgery are being made because of the high prevalence of low-back pain and the cost of diagnosis and treatment. Despite the possible cost reduction outpatient surgery can provide, there is a concern that it will influence the quality of surgery or patient outcome.⁴ Microdiscectomy and microlaminectomy are associated with a low rate of surgical complications, making them ideal for the outpatient setting, and thus they constitute 70%–90% of all outpatient spine surgery.⁵

While single-center studies have shown improved satisfaction, shorter recovery periods, and equivalent results in patients undergoing inpatient compared with outpatient decompression surgery, the assessments of safety and outcomes on a large scale have yet to be reported.^{6,7} The goal of this study was to compare the safety and efficacy of outpatient and inpatient lumbar laminectomy or laminotomy with or without discectomy.

Methods

Patient Cohort

The Lumbar Spine Surgery module of the Quality Outcomes Database (QOD),⁸ a quality registry instituted by the NeuroPoint Alliance, was queried for patients undergoing lumbar decompression surgery, defined as laminectomy or laminotomy with or without discectomy. The included patients were allocated to inpatient and outpatient groups based on their duration of hospital length of stay (LOS), with outpatients defined as those with an LOS of less than 24 hours. To increase the comparability of the two cohorts, we included only patients with one- or two-level surgeries, and we excluded patients with an LOS $\geq$ 72 hours from the main cohort because the prolonged stay was considered an indirect indicator of a complicated in-hospital course. We analyzed these patients separately to investigate differences in baseline characteristics and outcomes between them and the main cohort (Table 1).

Outcomes of Interest

The primary endpoints of this study were 30-day and 3-month readmission and reoperation rates. We also assessed nonroutine discharge (defined as discharge desti-

nation other than home), patient satisfaction, and decrease from baseline in Oswestry Disability Index (ODI), back pain, and leg pain 3 months after surgery. Patient satisfaction was measured based on the North American Spine Society (NASS) scale, a four-level scale in which 1 represents "The surgery met my expectations"; 2 represents "I did not improve as much as I had hoped, and I would not undergo the same treatment for the same outcome"; 3 represents "I did not improve as much as I had hoped, and I would not undergo the same treatment for the same outcome"; and 4 represents "I am the same or worse than before treatment."⁹ Patients were considered satisfied if they had an NASS score of 1 or 2. The intensity of back and leg pain at baseline and 3 months was measured via a numeric rating scale (NRS) (scores from 0 to 10).

Statistical Analysis

The hypothesis we aimed to test in this study was that outpatient surgery was noninferior to inpatient surgery in terms of 30-day and 3-month readmission and reoperation rates. For all four primary endpoints, the alternative hypothesis was that $p(o) < p(i) + d$, where $p(o)$ was the probability of the adverse outcome in the outpatient group, $p(i)$ was the probability of the adverse outcome in the inpatient group, and d was the acceptable difference (1.5% in this study). For noninferiority to be documented, the one-sided 97.5% confidence interval of the difference in risk between the two groups had to be less than 1.5. The value of d that we determined as acceptable in this study is significantly lower than respective values in sentinel studies of spinal literature.^{9–11} In summary, we aimed to assess whether the risk difference between outpatient and inpatient surgery for any of the four outcomes was over 1.5%.

Continuous data are presented in the form of means and standard deviations, while categorical data are presented as frequencies and proportions. An unpaired two-sample *t*-test was performed for the univariate analysis of continuous data, and Pearson's chi-square test was performed for categorical data. Age was broken down into tertiles based on distribution. Multivariable logistic regression was performed to identify characteristics independently associated with the outpatient or inpatient surgery status. R (version 4.1.1, The R Project for Statistical Computing) was used for all statistical analyses.¹² The results were considered statistically significant at $p < 0.05$. For the logistic regression, the *rms* package was utilized.

Optimal Matching

To create two highly homogeneous groups, we performed individual matching of patients in the two groups at a 1:1 ratio.¹³ Patients were matched on 38 baseline variables, including demographics, comorbidities, baseline symptomatology, baseline patient-reported outcomes

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TABLE 1. Comparison of included cohort (< 72 hours of stay) and excluded patients with ≥ 72 hours of stay on indicative baseline features and clinical outcomes

	LOS <72 hrs (n = 18,689)	LOS ≥72 hrs (n = 911)	Total (n = 19,600)	p Value
Age, yrs	56.0 (15.3)	63.2 (14.2)	56.3 (15.3)	<0.001
BMI	30.2 (6.2)	32.1 (7.1)	30.3 (6.3)	<0.001
LOS, days	0.5 (0.6)	5.8 (27.0)	0.7 (6.0)	<0.001
Smoking	3345 (17.9%)	128 (14.1%)	3473 (17.7%)	0.003
Female sex	8085 (43.3%)	455 (49.9%)	8540 (43.6%)	<0.001
Revision surgery	1667 (8.9%)	114 (12.5%)	1781 (9.1%)	<0.001
Diabetes mellitus	3222 (17.2%)	283 (31.1%)	3505 (17.9%)	<0.001
COPD	725 (3.9%)	59 (6.5%)	784 (4.0%)	<0.001
CAD	1819 (9.7%)	148 (16.2%)	1967 (10.0%)	<0.001
ASA class				<0.001
I or II	12,376 (66.2%)	353 (38.7%)	12,729 (64.9%)	
III or IV	6313 (33.8%)	558 (61.3%)	6871 (35.1%)	
Dependent ambulation	2328 (12.5%)	296 (32.5%)	2624 (13.4%)	<0.001
Symptomatic disc herniation	12,104 (64.8%)	363 (39.8%)	12,467 (63.6%)	<0.001
Grade 1 spondylolisthesis	1024 (5.5%)	95 (10.4%)	1119 (5.7%)	<0.001
Lumbar spinal stenosis	8631 (46.2%)	609 (66.8%)	9240 (47.1%)	<0.001
Adjacent-segment disease	341 (1.8%)	34 (3.7%)	375 (1.9%)	<0.001
ODI score at baseline	46.6 (17.6)	53.0 (17.9)	46.9 (17.7)	<0.001
Back pain (NRS score) at baseline	6.3 (2.9)	7.1 (2.7)	6.3 (2.9)	<0.001
Employment status				<0.001
Unemployed	8406 (45.0%)	603 (66.2%)	9009 (46.0%)	
Employed or on short-term leave	10,283 (55.0%)	308 (33.8%)	10,591 (54.0%)	
Insurance status				<0.001
Medicare	5721 (30.6%)	482 (52.9%)	6203 (31.6%)	
Medicaid	915 (4.9%)	58 (6.4%)	973 (5.0%)	
Private	11,248 (60.2%)	337 (37.0%)	11,585 (59.1%)	
Uninsured	190 (1.0%)	5 (0.5%)	195 (1.0%)	
VA/government	615 (3.3%)	29 (3.2%)	644 (3.3%)	
Levels treated				<0.001
1	5816 (31.1%)	204 (22.4%)	6020 (30.7%)	
2	12,873 (68.9%)	707 (77.6%)	13,580 (69.3%)	
Minimally invasive approach	4480 (24.0%)	115 (12.6%)	4595 (23.4%)	<0.001
Incidental durotomy	141 (0.8%)	70 (7.7%)	211 (1.1%)	<0.001
Length of op, mins	74.8 (36.6)	114.6 (56.1)	76.6 (38.6)	<0.001
Nonroutine discharge	94 (0.5%)	208 (22.8%)	302 (1.5%)	<0.001
Readmission w/in 30 days	773 (4.1%)	77 (8.5%)	850 (4.3%)	<0.001
Reop w/in 30 days	285 (1.5%)	59 (6.5%)	344 (1.8%)	<0.001
Readmission w/in 3 mos	1114 (6.0%)	113 (12.4%)	1227 (6.3%)	<0.001
Reop w/in 3 mos	559 (3.0%)	70 (7.7%)	629 (3.2%)	<0.001

VA = Veterans Affairs.

Values are presented as the number of patients (%) or mean (SD) unless stated otherwise. Boldface type indicates statistical significance.

(PROs), and operative variables, including the number of levels treated, the duration of surgery, and the occurrence of an incidental durotomy. The totality of the variables on which the groups were matched is presented in Tables 2 and 3. The value of standardized mean difference (SMD) for sufficient matching was set at < 0.1. The optimal matching algorithm from the *MatchIt* package was applied in this study.

Results

Study Cohort

The lumbar module of the QOD includes 72,504 patients. A flowchart outlining the filtering of the data set is presented in Fig. 1. A total of 19,600 patients with one- or two-level decompression and available 3-month follow-up were identified. Of these, 911 patients with LOS ≥ 72

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TABLE 2. Baseline characteristics of the outpatient and inpatient groups prior to matching

	Inpatient (n = 7565)	Outpatient (n = 11,124)	Total (n = 18,689)	p Value	SMD
Age, yrs					
Mean	59.4 (15.3)	53.6 (14.8)	56.0 (15.3)	<0.001	0.35
<50	1970 (26.0%)	4311 (38.8%)	6281 (33.6%)		
50–64	2269 (30.0%)	3811 (34.3%)	6080 (32.5%)	<0.001	
>64	3326 (44.0%)	3002 (27.0%)	6328 (33.9%)		
BMI	30.5 (6.4)	30.0 (6.2)	30.2 (6.2)	<0.001	0.074
LOS, hrs				<0.001	
<24	0 (0.0%)	11,124 (100.0%)	11,124 (59.5%)		
24–48	6402 (84.6%)	0 (0.0%)	6402 (34.3%)		
48–72	1163 (15.4%)	0 (0.0%)	1163 (6.2%)		
Smoking	1219 (16.1%)	2126 (19.1%)	3345 (17.9%)	<0.001	0.079
Female sex	3371 (44.6%)	4714 (42.4%)	8085 (43.3%)	0.003	0.044
Revision surgery	700 (9.3%)	967 (8.7%)	1667 (8.9%)	0.187	0.02
Osteoporosis	312 (4.1%)	289 (2.6%)	601 (3.2%)	<0.001	0.085
Diabetes mellitus	1593 (21.1%)	1629 (14.6%)	3222 (17.2%)	<0.001	0.168
COPD	333 (4.4%)	392 (3.5%)	725 (3.9%)	0.002	0.045
CAD	942 (12.5%)	877 (7.9%)	1819 (9.7%)	<0.001	0.152
Chronic kidney disease	226 (3.0%)	215 (1.9%)	441 (2.4%)	<0.001	0.068
Parkinson's disease	42 (0.6%)	29 (0.3%)	71 (0.4%)	0.001	0.046
Multiple sclerosis	26 (0.3%)	44 (0.4%)	70 (0.4%)	0.569	0.009
Anticoagulation at baseline	1788 (23.6%)	2829 (25.4%)	4617 (24.7%)	0.005	0.042
Depression	1595 (21.1%)	2089 (18.8%)	3684 (19.7%)	<0.001	0.058
Anxiety	1271 (16.8%)	2015 (18.1%)	3286 (17.6%)	0.021	0.035
ASA class				<0.001	0.356
I or II	4254 (56.2%)	8122 (73.0%)	12,376 (66.2%)		
III or IV	3311 (43.8%)	3002 (27.0%)	6313 (33.8%)		
Dependent ambulation	1220 (16.1%)	1108 (10.0%)	2328 (12.5%)	<0.001	0.184
Education level				<0.001	0.081
Graduate level	2797 (37.0%)	4496 (40.4%)	7293 (39.0%)		
High school or less	3621 (47.9%)	4886 (43.9%)	8507 (45.5%)		
Postgraduate level	1147 (15.2%)	1742 (15.7%)	2889 (15.5%)		
Symptomatic disc herniation	4039 (53.4%)	8065 (72.5%)	12,104 (64.8%)	<0.001	0.404
Grade 1 spondylolisthesis	532 (7.0%)	492 (4.4%)	1024 (5.5%)	<0.001	0.112
Lumbar spinal stenosis	4305 (56.9%)	4326 (38.9%)	8631 (46.2%)	<0.001	0.367
Adjacent-segment disease	196 (2.6%)	145 (1.3%)	341 (1.8%)	<0.001	0.093
Mechanical disc collapse	16 (0.2%)	22 (0.2%)	38 (0.2%)	0.838	0.003
ODI score at baseline	46.7 (17.4)	46.5 (17.8)	46.6 (17.6)	0.435	0.012
Leg pain (NRS score) at baseline	7.0 (2.6)	6.9 (2.6)	7.0 (2.6)	0.600	0.008
Back pain (NRS score) at baseline	6.4 (2.8)	6.2 (2.9)	6.3 (2.9)	<0.001	0.092
Self-reported race				0.002	0.053
African American	435 (5.8%)	703 (6.3%)	1138 (6.1%)		
Caucasian	6872 (90.8%)	10,133 (91.1%)	17,005 (91.0%)		
Other	258 (3.4%)	288 (2.6%)	546 (2.9%)		
Employment status				<0.001	0.354
Unemployed	4186 (55.3%)	4220 (37.9%)	8406 (45.0%)		
Employed or on short-term leave	3379 (44.7%)	6904 (62.1%)	10,283 (55.0%)		
Insurance status				<0.001	0.249
Medicare	3018 (39.9%)	2703 (24.3%)	5721 (30.6%)		
Medicaid	415 (5.5%)	500 (4.5%)	915 (4.9%)		

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TABLE 2. Baseline characteristics of the outpatient and inpatient groups prior to matching

	Inpatient (n = 7565)	Outpatient (n = 11,124)	Total (n = 18,689)	p Value	SMD
Insurance status (continued)					
Private	3772 (49.9%)	7476 (67.2%)	11,248 (60.2%)		
Uninsured	99 (1.3%)	91 (0.8%)	190 (1.0%)		
VA/government	261 (3.5%)	354 (3.2%)	615 (3.3%)		
Workers' compensation	261 (3.5%)	477 (4.3%)	738 (3.9%)	0.004	0.043
Liability claim	244 (3.2%)	366 (3.3%)	610 (3.3%)	0.807	0.004
Levels treated				<0.001	0.057
1	2236 (29.6%)	3580 (32.2%)	5816 (31.1%)		
2	5329 (70.4%)	7544 (67.8%)	12,873 (68.9%)		
Minimally invasive approach	1230 (16.3%)	3250 (29.2%)	4480 (24.0%)	<0.001	0.313
Incidental durotomy	99 (1.3%)	42 (0.4%)	141 (0.8%)	<0.001	0.102
Predominant symptom				0.002	0.043
Pain	6391 (84.5%)	9591 (86.2%)	15,982 (85.5%)		
Weakness	344 (4.5%)	420 (3.8%)	764 (4.1%)		
Numbness/tingling	830 (11.0%)	1113 (10.0%)	1943 (10.4%)		
Symptom duration, mos				<0.001	0.115
<3	1129 (14.9%)	2143 (19.3%)	3272 (17.5%)		
>3	6436 (85.1%)	8981 (80.7%)	15,417 (82.5%)		
Length of op, mins	86.9 (42.3)	66.5 (29.4)	74.8 (36.6)	<0.001	0.56

Values are presented as the number of patients (%) or mean (SD) unless stated otherwise. Boldface type indicates statistically significant differences represented as $p < 0.05$ and SMD > 0.1 .

hours were excluded to increase the homogeneity of the inpatient and outpatient groups. An analysis of baseline characteristics and outcomes of these patients compared with the rest of the cohort demonstrated that the excluded patients had significantly more comorbidities and worse preoperative status, as well as significantly worse postoperative outcomes (Table 1).

A total of 18,689 patients (11,124 outpatients and 7,565 inpatients) who underwent lumbar decompression surgery for ≤ 2 levels and with at least 3 months of follow-up were included in the main cohort. Baseline characteristics of this group prior to matching can be seen in Table 2. Patients undergoing outpatient lumbar discectomy were then optimally matched against inpatients in a 1:1 ratio, yielding two groups comprising 5016 patients each. After matching, the mean age was 56.8 (SD 14.8) years, the mean BMI was 30.2 (SD 6.2), and 44.1% of patients were female (Table 3).

Predictors of Inpatient Status

Multivariable logistic regression was performed to identify characteristics independently associated with a hospital LOS ≥ 24 hours (inpatient hospitalization). Factors associated with inpatient hospitalization included age > 64 years, female sex, diabetes mellitus, coronary artery disease (CAD), American Society of Anesthesiologists (ASA) class III or IV versus I or II, dependent ambulatory status, depression, lumbar stenosis, adjacent-segment disease, higher back pain NRS, other versus African American self-reported race, uninsured versus Medicare insurance status, incidental durotomy during surgery, leg and

back pain versus predominantly back pain, and increased length of surgery. BMI > 29 , smoking, chronic obstructive pulmonary disease (COPD), antiplatelet/anticoagulant use, anxiety, symptomatic disc herniation, private versus Medicare insurance status, active employment or on short-term leave status, and private insurance were associated with outpatient surgery (< 24 -hour LOS) (Fig. 2).

Nonroutine Discharge, Readmission, and Reoperation Rates

Nonroutine discharge was rare in both groups, and it was statistically significantly more common in the inpatient group than in the outpatient group (0.6% vs 0.3%, $p = 0.01$; Table 4). The overall readmission rate at 30 days was 4.3% and was not significantly different between inpatient (4.3%) and outpatient (4.4%) groups ($p = 0.77$). The overall reoperation rate at 30 days was 1.4% and was not significantly different between inpatient (1.5%) and outpatient (1.4%) groups ($p = 0.45$). At 3 months, the overall readmission rate was 6.3% and was not significantly different between groups (6.3 vs 6.3%, $p = 0.87$). The overall reoperation rate at 3 months was 3.0% and also not significantly different between groups (2.9 vs 3.1%, $p = 0.68$).

Noninferiority of outpatient surgery, when compared with inpatient surgery, was documented for all primary outcomes (Fig. 3).

Three-Month PROs

Overall satisfaction (NASS score 1 or 2) at 3 months was 88.6% and was similar between outpatient and in-

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TABLE 3. Baseline characteristics of the outpatient and inpatient groups after matching

	Inpatient (n = 5016)	Outpatient (n = 5016)	Total (n = 10,032)	p Value	SMD
Age, yrs					
Mean	56.8 (14.8)	56.8 (14.8)	56.8 (14.8)	0.946	0.001
<51	1655 (33.0%)	1643 (32.8%)	3298 (32.9%)	0.928	
>65	1680 (33.5%)	1698 (33.9%)	3378 (33.7%)		
51–65	1681 (33.5%)	1675 (33.4%)	3356 (33.5%)		
BMI	30.3 (6.2)	30.2 (6.2)	30.2 (6.2)	0.601	0.010
LOS, days					
0	0 (0.0%)	5016 (100.0%)	5016 (50.0%)	<0.001	
1	4416 (88.0%)	0 (0.0%)	4416 (44.0%)		
2	600 (12.0%)	0 (0.0%)	600 (6.0%)		
Smoking	841 (16.8%)	858 (17.1%)	1699 (16.9%)	0.651	0.009
Female sex	2269 (45.2%)	2157 (43.0%)	4426 (44.1%)	0.024	0.045
Revision surgery	458 (9.1%)	424 (8.5%)	882 (8.8%)	0.231	0.024
Osteoporosis	179 (3.6%)	164 (3.3%)	343 (3.4%)	0.410	0.016
Diabetes mellitus	943 (18.8%)	876 (17.5%)	1819 (18.1%)	0.083	0.035
COPD	199 (4.0%)	218 (4.3%)	417 (4.2%)	0.342	0.019
CAD	534 (10.6%)	525 (10.5%)	1059 (10.6%)	0.770	0.006
Chronic kidney disease	128 (2.6%)	126 (2.5%)	254 (2.5%)	0.899	0.003
Parkinson's disease	22 (0.4%)	21 (0.4%)	43 (0.4%)	0.879	0.003
Multiple sclerosis	13 (0.3%)	19 (0.4%)	32 (0.3%)	0.288	0.021
Anticoagulation at baseline	1040 (20.7%)	1181 (23.5%)	2221 (22.1%)	<0.001	0.068
Depression	1045 (20.8%)	992 (19.8%)	2037 (20.3%)	0.188	0.026
Anxiety	871 (17.4%)	865 (17.2%)	1736 (17.3%)	0.874	0.003
ASA class					
I or II	3192 (63.6%)	3192 (63.6%)	6384 (63.6%)	>0.999	<0.001
III or IV	1824 (36.4%)	1824 (36.4%)	3648 (36.4%)		
Dependent ambulation	527 (10.5%)	527 (10.5%)	1054 (10.5%)	>0.999	<0.001
Education level					
Graduate level	1908 (38.0%)	1920 (38.3%)	3828 (38.2%)	0.191	0.036
High school or less	2381 (47.5%)	2311 (46.1%)	4692 (46.8%)		
Postgraduate level	727 (14.5%)	785 (15.6%)	1512 (15.1%)		
Symptomatic disc herniation	3162 (63.0%)	3162 (63.0%)	6324 (63.0%)	>0.999	<0.001
Grade 1 spondylolisthesis	179 (3.6%)	179 (3.6%)	358 (3.6%)	>0.999	<0.001
Lumbar spinal stenosis	2463 (49.1%)	2434 (48.5%)	4897 (48.8%)	0.562	0.012
Adjacent-segment disease	103 (2.1%)	84 (1.7%)	187 (1.9%)	0.161	0.028
Mechanical disc collapse	8 (0.2%)	8 (0.2%)	16 (0.2%)	>0.999	<0.001
ODI score at baseline	46.9 (17.5)	46.4 (17.5)	46.6 (17.5)	0.124	0.031
Leg pain (NRS score) at baseline	7.0 (2.6)	6.9 (2.6)	7.0 (2.6)	0.405	0.017
Back pain (NRS score) at baseline	6.4 (2.8)	6.3 (2.9)	6.3 (2.8)	0.226	0.024
Self-reported race				0.234	0.034
African American	280 (5.6%)	279 (5.6%)	559 (5.6%)		
Caucasian	4560 (90.9%)	4591 (91.5%)	9151 (91.2%)		
Other	176 (3.5%)	146 (2.9%)	322 (3.2%)		
Employment status					
Unemployed	2457 (49.0%)	2370 (47.2%)	4827 (48.1%)	0.082	0.035
Employed or on short-term leave	2559 (51.0%)	2646 (52.8%)	5205 (51.9%)		
Insurance status					
Medicare	1705 (34.0%)	1647 (32.8%)	3352 (33.4%)	0.109	0.055
Medicaid	256 (5.1%)	245 (4.9%)	501 (5.0%)		

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TABLE 3. Baseline characteristics of the outpatient and inpatient groups after matching

	Inpatient (n = 5016)	Outpatient (n = 5016)	Total (n = 10,032)	p Value	SMD
Insurance status (continued)					
Private	2820 (56.2%)	2907 (58.0%)	5727 (57.1%)		
Uninsured	60 (1.2%)	38 (0.8%)	98 (1.0%)		
VA/government	175 (3.5%)	179 (3.6%)	354 (3.5%)		
Workers' compensation	200 (4.0%)	197 (3.9%)	397 (4.0%)	0.878	0.003
Liability claim	154 (3.1%)	150 (3.0%)	304 (3.0%)	0.816	0.005
Levels treated				0.668	0.009
1	1613 (32.2%)	1593 (31.8%)	3206 (32.0%)		
2	3403 (67.8%)	3423 (68.2%)	6826 (68.0%)		
Minimally invasive approach	816 (16.3%)	816 (16.3%)	1632 (16.3%)	>0.999	<0.001
Incidental durotomy	3 (0.1%)	3 (0.1%)	6 (0.1%)	>0.999	<0.001
Predominant symptom				0.579	0.021
Pain	4248 (84.7%)	4245 (84.6%)	8493 (84.7%)		
Weakness	200 (4.0%)	219 (4.4%)	419 (4.2%)		
Numbness/tingling	568 (11.3%)	552 (11.0%)	1120 (11.2%)		
Symptom duration, mos				0.688	0.008
<3	829 (16.5%)	844 (16.8%)	1673 (16.7%)		
>3	4187 (83.5%)	4172 (83.2%)	8359 (83.3%)		
Length of op, mins	74.0 (27.7)	73.5 (27.8)	73.8 (27.7)	0.348	0.019

Values are presented as the number of patients (%) or mean (SD) unless stated otherwise. Boldface type indicates statistical significance.

patient groups (88.4 vs 88.8%, $p = 0.53$; Table 5). Noninferiority at the specified margin of 1.5% risk difference was demonstrated for outpatient compared with inpatient surgery. The ODI score at 3 months was lower in the outpatient compared with inpatient group (20.7 vs 22.4, $p < 0.001$). The decrease from baseline ODI score and the percentage of patients achieving minimal clinically important difference (MCID) in ODI score at 3 months were significantly greater in the outpatient cohort (25.7 vs 24.5, $p < 0.001$; and 73.8% vs 71.6%, $p = 0.01$).

The mean NRS leg pain score at 3 months was 2.3 in the outpatient and 2.4 in the inpatient cohorts, demonstrating a decrease by 4.6 points from baseline in both groups. Despite the fact that differences in the mean 3-month leg pain were not statistically significant, the rate of MCID achievement was, favoring outpatient surgery. Regarding NRS back pain, outpatient surgery was associated with slightly lower scores at 3 months, which were not significant in terms of MCID achievement.

Discussion

The estimated cost of resources targeted toward the diagnosis and management of low-back pain each year is approximately \$90 billion.³ Given the substantial cost associated with spinal disorders, efforts to reduce cost in this field are critical. Specifically, lumbar decompression is one of the most common surgical procedures performed in the US across all specialties, with more than 450,000 procedures performed annually.¹ A transition from inpatient to ambulatory surgical centers (ASCs) for spinal disorders has progressed rapidly. This transition has been associated

with cost savings of more than \$2000–\$3500/case without evidence of compromising outcomes, complications, or readmission rates.^{6,14,15}

Other presumed benefits of outpatient spine surgery include earlier and greater patient mobilization leading to lower rates of deep venous thrombosis and atelectasis, decreased rates of postoperative urinary retention, and a shorter duration of exposure to virulent hospital pathogens that may potentially result in fewer cases of hospital-acquired pneumonias and other infections. Several other surgical subspecialties have shifted to more outpatient-based treatments with a trend toward decreased complication rates.^{4,16–19}

The safety and efficacy of outpatient lumbar spine surgery have been previously reported, with studies demonstrating improved satisfaction, shorter recovery periods, and lower complication rates with outpatient surgery.^{6,7,20–25} However, the majority of these studies involve smaller, single-center patient cohorts. These studies have demonstrated the safety and efficacy of outpatient cervical surgery in select populations.^{26–35}

Patient selection remains key in determining those most likely to benefit from early mobilization and discharge, with patient comorbidities, preoperative baseline function, and nature of pathology all contributing to this decision. Prior studies have suggested that ideal candidates for outpatient surgery include those < 70 years of age with low patient comorbidity (ASA classes I and II) and ideally single-level pathology.^{25,36} Alternatively, an inpatient stay allows for close monitoring of the surgical wound for infection or hematoma formation as well as neurological changes possibly requiring urgent intervention. Some sur-

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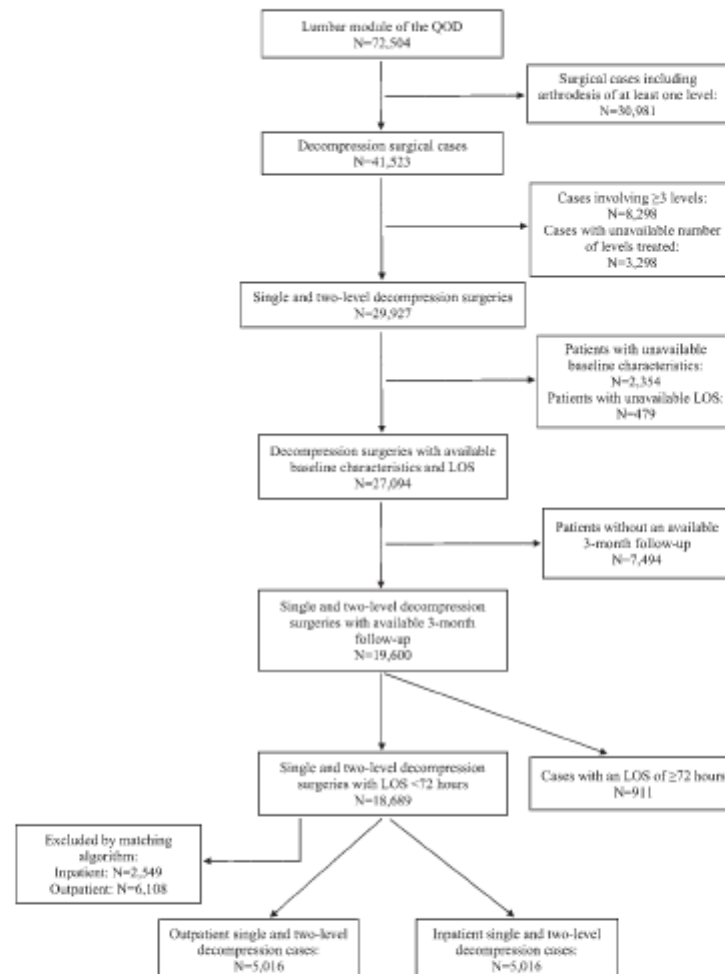


FIG. 1. Flowchart of the filtering process of the total cohort, with reasons for exclusion and respective patient numbers.

geons have cautioned against the increasing prevalence of outpatient procedures.⁴

An important consideration when examining the literature is the definition of outpatient surgery. Prior studies examining anterior cervical discectomy and fusion and lumbar discectomy have defined outpatient status as patients who were discharged the same day^{37,38} or patients who stayed ≤ 1 night at the hospital,^{39,39} and some studies did not provide a quantitative definition.⁴⁰ A study examining the ACS-NSQIP (American College of Surgeons National Surgical Quality Improvement) database definition of outpatient versus inpatient anterior cervical discectomy and fusion and lumbar discectomy found that 41% of "outpa-

tient" lumbar discectomy patients had an LOS > 0 days.⁴¹ In the present study, outpatient surgery was defined as patient admission and discharge within a 24-hour period. However, this cutoff may have also included patients who underwent afternoon surgery and were kept overnight. Unfortunately, these two different patient groups could not be separately analyzed utilizing the QOD metrics.

Additionally, outpatient surgery can be performed in a hospital setting or ASC. Outpatient spine surgery in a hospital setting eases the ability to convert a patient from observation status to full inpatient admission. On the contrary, ASCs typically require admission and discharge on the same calendar day. While the majority of participating

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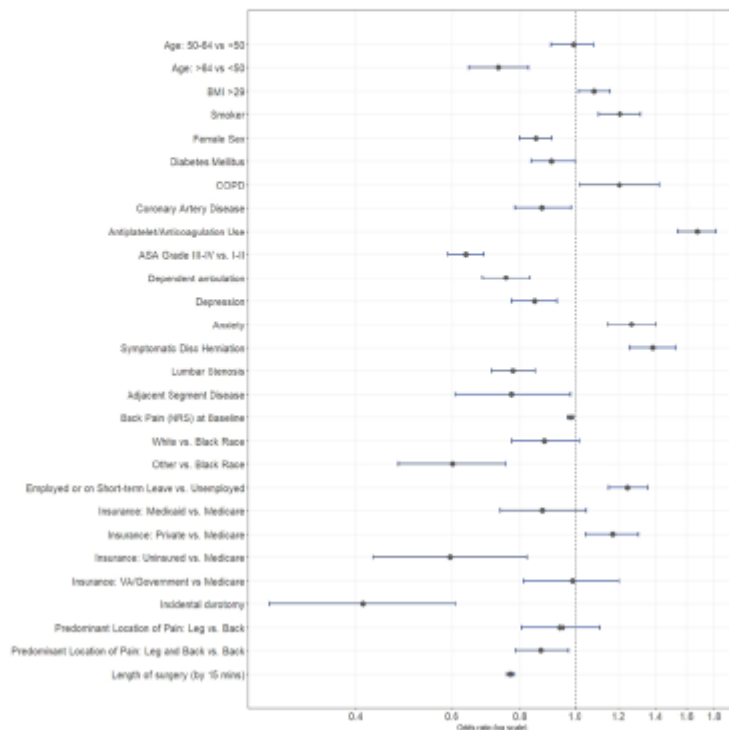


FIG. 2. Multivariable analysis of baseline patient characteristics associated with allocation to the inpatient or the outpatient group. Odds ratios and 95% confidence intervals are represented. Figure is available in color online only.

QOD sites are large academic centers, some operations were performed in ASCs affiliated with a participating site. However, the QOD is not designed to capture this specific data point.

The present study identified factors that carry bias toward an inpatient stay after lumbar decompression surgery, including age > 64 years, CAD, higher ASA class, dependent ambulation, incidental durotomy, and longer duration of surgery. Interestingly, among the features associated with outpatient surgery was a patient history of COPD and antiplatelet/anticoagulant use. Both these fac-

tors may seem counterintuitive; however, another possible explanation would be that the predisposition of the former group of patients to lower respiratory infections and of the latter to venous thromboembolism may incentivize providers to reinforce early mobilization and shorter hospitalization. Unfortunately, being unable to distinguish between antiplatelet and anticoagulant use and not having access to perioperative administration details, we could not investigate this topic further.

The study design sought to control all of these factors through optimal matching across 38 covariates, including

TABLE 4. Comparison between outpatient and inpatient groups in terms of clinical outcomes

	No. of Patients (%)			p Value
	Inpatient (n = 5016)	Outpatient (n = 5016)	Total (n = 10,032)	
Nonroutine discharge	32 (0.6)	15 (0.3)	47 (0.5)	0.013
Readmission w/in 30 days	215 (4.3)	221 (4.4)	436 (4.3)	0.769
Reop w/in 30 days	77 (1.5)	68 (1.4)	145 (1.4)	0.452
Readmission w/in 3 mos	314 (6.3)	318 (6.3)	632 (6.3)	0.869
Reop w/in 3 mos	146 (2.9)	153 (3.1)	299 (3.0)	0.681

Boldface type indicates statistical significance.

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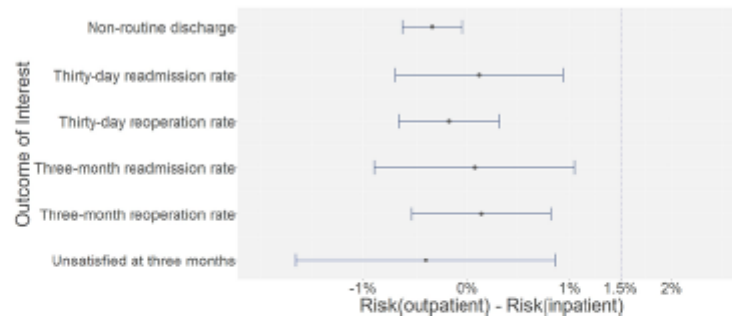


FIG. 3. Plot of noninferiority analysis for 3-day and 3-month readmission and reoperation rates. The noninferiority cutoff is set at a risk difference of 1.5%. Risk difference and 95% confidence intervals are presented. Figure is available in color online only.

multiple patient comorbidities and anatomical variables. In the comparative analysis, we included only patients with ≤ 2 levels treated who stayed < 72 hours total to best isolate for the influence of an outpatient versus inpatient stay and to maximize clinical equipoise. A comparative analysis of patients with ≥ 72 -hour LOS and the rest of the cohort demonstrated significant differences in terms of baseline characteristics and outcomes, justifying our decision to exclude the former group from the comparative analysis.

Our analyses demonstrated no significant differences in 30-day or 3-month reoperation and readmission rates between outpatient and inpatient groups. Additionally, we were able to document noninferiority of outpatient lumbar decompression to inpatient surgery for these primary outcomes.

Nonroutine discharge was found to be slightly lower with outpatient surgery. This could be attributed to potential differences between patient populations for which we could not adjust, but it could also be a finding, representing the effect of early patient mobilization and decreased

exposure to the hospital environment. Regarding PROs, outpatient surgery demonstrated a statistically significant advantage in ODI scores, NRS leg pain scores, and NRS back pain scores at 3 months; these differences were statistically significant but of limited clinical importance. Importantly, noninferiority of outpatient surgery at the 3-month follow-up in terms of patient-reported satisfaction was found, which has not been documented in the literature, to our knowledge.

This multicenter registry study represents the largest cohort of patients ($n = 19,600$) examined thus far regarding outcomes, complications, and reoperation rates after outpatient versus inpatient lumbar discectomy. This is also the first noninferiority study on the topic, and it is sufficiently powered to detect a risk difference as small as 1.5%. Pughly et al. used a propensity score-adjusted prospective cohort study design comparing 2658 inpatients and 1652 outpatients who underwent lumbar discectomy and found a higher rate of complications for inpatients.⁴⁰ However, that study only examined 30-day morbidity from the NSQIP

TABLE 5. Comparison between outpatient and inpatient groups in terms of PROs

	Inpatient (n = 5016)	Outpatient (n = 5016)	Total (n = 10,032)	p Value
Satisfaction (NASS score 1 or 2) at 3 mos	4433 (88.4%)	4453 (88.8%)	8886 (88.6%)	0.530
Maximal satisfaction (NASS score 1) at 3 mos	3365 (67.1%)	3403 (67.8%)	6768 (67.5%)	0.418
ODI score at baseline	46.9 (17.5)	46.4 (17.5)	46.6 (17.5)	0.124
ODI score at 3 mos	22.4 (18.9)	20.7 (19.0)	21.6 (19.0)	<0.001
Decrease from baseline in ODI score at 3 mos	24.5 (21.1)	25.7 (21.2)	25.1 (21.1)	0.004
MCID in ODI score at 3 mos	3587 (71.6%)	3702 (73.8%)	7289 (72.7%)	0.010
Leg pain (NRS) at baseline	7.0 (2.6)	6.9 (2.6)	7.0 (2.6)	0.405
Leg pain (NRS) at 3 mos	2.4 (2.9)	2.3 (2.9)	2.4 (2.9)	0.076
Decrease from baseline in leg pain at 3 mos	4.6 (3.6)	4.6 (3.5)	4.6 (3.5)	0.406
MCID in leg pain at 3 mos	3925 (78.2%)	4016 (80.1%)	7941 (79.2%)	0.025
Back pain (NRS) at baseline	6.4 (2.8)	6.3 (2.9)	6.3 (2.8)	0.226
Back pain (NRS) at 3 mos	2.9 (2.8)	2.7 (2.7)	2.8 (2.7)	0.001
Decrease from baseline in back pain at 3 mos	3.5 (3.3)	3.6 (3.3)	3.6 (3.3)	0.110
MCID in back pain at 3 mos	3635 (72.5%)	3692 (73.6%)	7327 (73.0%)	0.200

Values are presented as the number of patients (%) or mean (SD) unless stated otherwise. Boldface type indicates statistical significance.

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and did not include PROs. In contrast, in our analysis, the noninferiority of outpatient compared with inpatient surgery in terms of patient satisfaction was documented. Additionally, in the study by Pugely et al., the superiority of outpatient surgery in terms of 30-day morbidity most likely reflects insufficient clinical equipoise due to the lack of granularity of the registry they used.^{40,42} Helseth et al. prospectively recorded complications and readmissions in 1449 outpatients undergoing cervical (n = 376) and lumbar (n = 1073) procedures.²⁵ They reported a 3.5% overall complication rate and a 1.5% 3-month readmission rate. Importantly, all life-threatening hematomas in this series were detected within 3 hours after lumbar spinal surgery. These studies and others have all demonstrated the comparative safety and cost savings associated with outpatient spine surgery.^{7,20,21,23,24,43,44}

Given the demonstration of noninferiority of outpatient lumbar discectomy in terms of nonroutine discharge, 30-day and 3-month readmissions, reoperations, and patient-reported satisfaction compared with inpatient surgery, the present study provides robust evidence encouraging outpatient lumbar decompression surgery. The fact that the conclusions of this study are drawn from real-world data with significant clinical comparability between the groups studied further enhances the clinical applicability of the findings.

While attempts have already been made to identify optimal patients for outpatient cervical surgery,^{34,45} future studies using large databases may seek to determine the optimal patient population for outpatient lumbar surgery. These may serve to expand indications for outpatient surgery to those in need of arthrodesis and other more complex lumbar procedures. The increased adoption of and proficiency with minimally invasive techniques will further spur the trend toward outpatient-based spinal procedures. These efforts will allow for maximal healthcare cost reduction and create more optimal resource utilization at a time when these topics are at the forefront of healthcare economic policy.

Limitations

There are some limitations to the current study. First, this was an observational study, and patients were not randomized. Surgeon choice to perform outpatient versus inpatient surgery introduces an inherent selection bias, with outpatient procedures involving younger patients with fewer comorbidities. To control for this, optimal matching was performed across 38 variables of interest with SMD < 0.1 for all variables. Although we employed optimal individual matching to reduce potential bias from confounding variables, it is possible that variables not collected and adjusted for could have affected the results. Specifically, preoperative opioid usage, significant blood loss, and bilateral procedures have been associated with unfavorable postoperative course, and these data points were not matched for in the present study. As with any study using a multi-institutional registry, this analysis is liable to the effect of diversity in practice among providers and hospitals; we could not measure or adjust for such an effect. While outpatient surgery was defined as LOS < 24 hours, this could also include patients kept overnight for observa-

tion. Additionally, while the QOD primarily includes data from large academic and hospital-based centers, some operations were performed at ASCs, and these two different groups could not be separately analyzed using QOD metrics. Finally, early postoperative morbidity was illustrated as readmissions and reoperations, but minor complications that did not require hospitalization were not captured.

Conclusions

Lumbar spine decompression surgery represents an ideal target for healthcare cost reduction. Outpatient lumbar decompression surgery demonstrated noninferior outcomes at 30 days and 3 months after surgery compared with inpatient surgery. Spine surgeons should consider outpatient lumbar decompression surgery in appropriately selected patients, encouraging early patient mobilization and decreasing the risks of hospital-associated complications and infections while maximizing healthcare savings.

Acknowledgments

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In Memoriam

It is with the deepest regret that we report the passing of Dr. Clinton J. Devin on December 10, 2021. Dr. Devin was one of the founders of the Quality Outcomes Database, as well as an exemplary surgeon, a prolific scientist, and a dear colleague and friend. He will be greatly missed and always remembered by all of us.

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Purpose of the Project

Same-day spine surgery at an ambulatory surgical center versus hospital outpatient department: a propensity-matched analysis of complications and patient-reported outcomes using the Michigan Spine Surgery Improvement Collaborative Registry

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OBJECTIVE Although many authors have shown the safety of outpatient spine surgery, few have compared same-day spine surgery in the ambulatory surgical center (ASC) versus the hospital outpatient department (HOPD). The purpose of this study was to compare the safety of anterior cervical arthrodesis/arthroplasty or lumbar decompression with same-day discharge performed at the ASC versus HOPD.

METHODS After IRB approval, a retrospective, propensity-matched, comparative cohort analysis of a statewide, prospective, multicenter, spine-specific database (Michigan Spine Surgery Improvement Collaborative [MSSIC]) was undertaken. Patients who underwent lumbar decompression or anterior cervical arthrodesis/arthroplasty (1 or 2 levels) with same-day discharge from January 1, 2021, to June 30, 2023, were reviewed. The HOPD/ASC matched cohorts were created at a ratio of 4:1 based on BMI, American Society of Anesthesiologists physical status class (ASA), and operative levels. The primary outcome variables investigated included any complication, return to operating room (OR) within 90 days, and emergency department (ED) visit or readmission within 30 and 90 days. Secondary outcome measures investigated included patient-reported outcome (PRO) measures at 90 days and 1 year and return to work at 90 days and 1 year. Differences between HOPD and ASC patients were tested using univariate comparisons for both the anterior cervical and lumbar decompression cohorts. Multivariate analysis was performed for the lumbar decompression group.

RESULTS After matching, 3351 patients who underwent outpatient lumbar decompression (2679 HOPD and 672 ASC) and 805 patients who underwent anterior cervical arthrodesis/arthroplasty (644 HOPD and 162 ASC) were included in the analysis. In the univariate analysis for anterior cervical arthrodesis/arthroplasty, there were no differences between HOPD and ASC groups in terms of any complication, PROs at 90 days or 1 year, and return to work at 90 days and 1 year ($p > 0.05$). In the univariate analysis of the lumbar decompression group, there were higher rates of complications and return to the OR for the ASC group compared to the HOPD group (8% vs 5.5% [$p = 0.01$] and 4.9% vs 2.1% [$p < 0.001$], respectively), which remained in the multivariate analysis (incidence rate ratio [IRR] 1.5 [$p = 0.001$] and IRR 2.3 [$p < 0.001$], respectively). There were no differences between the groups in terms of PROs at 90 days and 1 year.

CONCLUSIONS Although both outpatient anterior cervical surgery and lumbar decompression can be performed safely and effectively in ASC and HOPD, there is a slightly higher risk of return to the OR for patients who undergo lumbar

ABBREVIATIONS ACDF = anterior cervical discectomy and fusion; ASA = American Society of Anesthesiologists physical status class; ASC = ambulatory surgical center; CAD = coronary artery disease; CDA = cervical discectomy and arthroplasty; CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease; DVT = deep vein thrombosis; ED = emergency department; HOPD = hospital outpatient department; IRR = incidence rate ratio; MCI = minimal clinically important difference; MSSIC = Michigan Spine Surgery Improvement Collaborative; OR = operating room; PRO = patient-reported outcome; SSI = surgical site infection.

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decompression in the ASC. Given similar outcomes, future studies should focus on patient and payer cost differences between ASC and HOPD.

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KEYWORDS outpatient spine surgery; same-day spine surgery; hospital outpatient department; lumbar decompression; anterior cervical discectomy and fusion; anterior cervical arthroplasty; degenerative

IMPROVEMENTS in patient education/preparation, surgical technique, perioperative anesthesia, and multimodal pain management have resulted in increased migration of spine surgery from the inpatient to the outpatient setting.¹ Many spine surgical procedures have been safely performed without an inpatient stay, most commonly anterior cervical discectomy and fusion (ACDF) or anterior cervical discectomy and arthroplasty (CDA)²⁻¹⁴ and lumbar laminectomy and/or microdiscectomy.^{15,16} Less commonly, lumbar arthrodesis, lumbar disc replacement, and multilevel cervical arthrodesis (≥ 3 levels) have been done safely in the outpatient setting.¹⁷⁻²¹

Given the migration of care to the outpatient setting, freestanding ambulatory surgical centers (ASCs) have grown as sites of service for spine surgical procedures. Compared to hospital outpatient departments (HOPDs), ASCs may offer a significantly lower cost of care without sacrificing outcomes, leading to better value for both patients and payers.²² Additionally, ASCs may also offer an opportunity to improve patient satisfaction by offering a more personalized experience and more expeditiously completing procedures and discharging patients home.^{23,24}

Despite the safety of outpatient spine surgery and the enthusiasm surrounding patient experience improvement, spine surgery migration from HOPD to ASC has been slow. Overall, the growth of spine surgery at ASCs has not kept up with the rate of outpatient surgery performed at HOPDs.²⁵ Some authors have questioned the safety of performing spine surgery in an ASC, which may be due to surgeon preference or fear of complications away from the support of a hospital.²⁶⁻²⁸ Another barrier to transition could be related to hospital employment of surgeons and lack of available resources to perform surgery at an ASC. Additionally, conflicts regarding the definition of "outpatient" (same-day discharge vs 23-hour observation), and their implications on the ability to adequately compare spine surgery performed in the ASC versus the hospital, have led to misleading or poorly generalizable results in the literature.²⁹ Given this, we performed a retrospective study of a prospectively maintained, statewide, spine-specific database to compare the clinical outcomes, complications, and reoperations between spine surgery performed in an ASC versus HOPD with same-day discharge.

Methods

This study was conducted in accordance with an IRB-approved protocol and complied with all local, state, and federal regulations.

Patient Selection/Matching

After IRB approval, the Michigan Spine Surgery Improvement Collaborative (MSSIC) registry, a prospectively maintained, statewide, spine-specific database, was

queried for all patients who underwent outpatient ACDF (1 or 2 levels), CDA (1 or 2 levels), or lumbar decompression (ascertained through review of operative notes) with same-day discharge from January 1, 2021, to June 30, 2023, and were followed for 1 year from their index operation. Details regarding MSSIC, including member facilities, patient characteristics, and data characteristics, have been previously published.³⁰⁻³² A retrospective review of prospectively collected data was conducted, comparing patients who underwent a spine surgical procedure in an ASC with those who had it performed at an HOPD with same-day discharge.

Outcome Measures

The primary outcome variable investigated was any complication (mortality, cerebrospinal fluid leak, deep vein thrombosis [DVT]/pulmonary embolism, ileus, myocardial infarction, myelopathy, new neurological deficit, stroke, surgical site infection [SSI], urinary retention, wound dehiscence, return to operating room [OR], and readmission), determined through abstraction of the medical record (surgeon notes, hospital records, operative reports, etc.), as described previously.^{31,32} Return to OR and readmission were also investigated individually. Secondary outcomes included patient-reported outcomes (PROs) at 90 days and 1 year (i.e., PROMIS Physical Function score, patient satisfaction based on the North American Spine Society patient satisfaction index, EQ-5D score, and 0- to 10-point score on the numeric rating scale for back/leg pain for lumbar patients and neck/arm pain for cervical patients). Additionally, emergency department (ED) visit within 90 days after discharge and return to work at 90 days and 1 year were also examined.

Statistical Analysis

Univariate analysis was performed for anterior cervical and lumbar decompression patient groups, comparing ASC and HOPD cohorts within each group. A propensity score-matching approach was used to balance the distribution of baseline covariates between HOPD and ASC patients. First, propensity scores were estimated using multivariate logistic regression, in which patient BMI, American Society of Anesthesiologists physical status class (ASA), and number of levels were the predictors of being operated on in an HOPD or ASC. These variables were selected on the basis of the literature of factors supporting an ASC setting for spine surgical procedures. After propensity score estimation, we performed tests to confirm that the mean propensity scores did not differ between the HOPD and ASC groups, and balance was achieved between the HOPD and ASC groups for the 3 variables included in the regression model (BMI, ASA, and number of levels). HOPD cases were then matched to ASC cases using the

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propensity scores. We employed a caliper matching and (optionally) exact matching algorithm, without replacement, given the advantage of improved comparability of groups and less bias. Caliper width was set at 0.2 of the standard deviation of the logit of the propensity score, following common practice. A 4:1 matching ratio between HOPD and ASC cases was chosen considering that we had almost 6 times more HOPD cases than ASC cases. Matching multiple HOPD cases to 1 ASC case can improve the representativeness of the HOPD group, substantially increase the overall sample size, and therefore increase statistical power and precision. Differences between HOPD and ASC patients were tested using the chi-square or Fisher's exact tests for categorical variables, t-tests for normally distributed variables, and Mann-Whitney U-tests for variables that were not normally distributed.

Multivariate analysis was performed for the matched lumbar decompression cohorts to help further control for differences in baseline characteristics after matching. The generalized estimating equation model was employed to control variance structure and clustering error. A Poisson family distribution with robust variance estimates and a log link function were also used to directly estimate risk ratios for nonrare outcomes. Incidence rate ratios (IRRs) and p values for different outcome measures were calculated. Multivariate analysis for the anterior cervical cohort was not performed, as the small sample size limited our ability to detect a significant difference.

Results

In total, 5266 patients who underwent outpatient lumbar decompression and 1144 patients who underwent outpatient ACDF/CDA were included in the initial review. After undergoing matching based on BMI, ASA > II, and number of levels operated on, 3351 (63.6%) patients who underwent outpatient lumbar decompression (2679 HOPD and 672 ASC) and 806 (70.4%) patients who underwent anterior cervical arthrodesis/arthroplasty (644 HOPD and 162 ASC) were included in the analysis. Baseline sociodemographic and comorbid conditions in the prematched and matched ACDF/CDA and lumbar decompression cohorts are shown in Tables 1 and 2, respectively. Baseline PROs are shown in Table 3.

After initial matching, the ACDF/CDA cohorts demonstrated no significant difference in baseline characteristics, including age, sex, education, private insurance, smoking status, BMI, history of diabetes, DVT, coronary artery disease (CAD), anxiety, hypertension, osteoporosis, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), preoperative daily opioid use, ASA, independent preoperative ambulation, previous spine surgery, and employment status ($p > 0.05$). Small differences remained in race and symptom duration ($p < 0.05$) (Table 1). Lumbar decompression cohorts showed no significant difference with regard to private insurance, BMI, history of diabetes, CAD, hypertension, CHF, ASA, independent preoperative ambulation, and previous spine surgery ($p > 0.05$). However, differences remained in age, sex, race, education, smoking status, history of DVT, depression, anxiety, osteoporosis, COPD, preoperative daily

opioid use, symptom duration, and employment status ($p < 0.05$) (Table 2).

Surgical characteristics are shown in Table 4. All included patients had same-day discharge. In the ACDF/CDA comparison, there were similar proportions of patients who underwent single- versus 2-level surgery (67.6% of 1-level and 32.5% of 2-level procedures in HOPD, vs 64.2% of 1-level and 35.8% of 2-level procedures in ASC, $p = 0.418$). There was a statistically shorter length of surgery, lower estimated blood loss, and higher proportion of patients with ambulation within 8 hours in the ASC cohort compared to the HOPD cohort ($p < 0.05$). In the lumbar decompression comparison, there were similar number of levels and similar estimated blood loss between HOPD and ASC cohorts ($p > 0.05$). Lumbar decompression patients who underwent surgery in ASC had a higher proportion of patients who underwent laminectomy alone, lower proportion of patients who underwent laminectomy and discectomy, shorter length of surgery, and higher proportion of patients who ambulated within 8 hours compared to patients who underwent surgery in HOPD ($p < 0.05$).

Univariate comparisons of adverse events are shown in Table 5. Patients who underwent ACDF/CDA with same-day discharge had similar levels of adverse events (i.e., any complication, readmission within 30 or 90 days, ED visit, return to OR, urinary retention, dysphagia, or ileus) whether the surgery was performed in ASC or HOPD ($p > 0.05$). Patients who underwent lumbar decompression largely had similar levels of adverse events (i.e., readmission within 30 or 90 days, ED visit, urinary retention, or ileus) ($p > 0.05$); however, ASC patients had a higher rate of any complication ($p = 0.011$) than HOPD patients, driven primarily by return to OR. Given the imbalances in baseline characteristics for the lumbar decompression group even after matching, a follow-up multivariate regression was performed to further compare HOPD and ASC groups. After multivariate analysis, the ASC cohort had a higher risk of any complication (IRR 1.5, $p = 0.001$), driven primarily by return to the OR (IRR 2.3, $p < 0.001$) (Table 6). When examining the higher rate of return to OR in the ASC population, we found that this finding was driven primarily by lumbar reherniation requiring reoperation (3.2% in ASC cohort vs 1.0% in the HOPD cohort) (Table 7).

Postoperative PROs are shown in Table 8. There were no differences in the proportions of patients who achieved minimal clinically important difference (MCID) in any PRO measured at 90 days and 1 year between patients who underwent ACDF/CDA at ASC versus HOPD ($p > 0.05$). Additionally, there were no differences in return to work at 90 days or 1 year between the ASC and HOPD cohorts for ACDF/CDA ($p > 0.05$) (Table 8).

In the lumbar decompression group, there was a slightly higher proportion of patients who achieved MCID for visual analog score for leg pain improvement at 90 days in those treated at ASC versus those treated at HOPD (86.1% vs 82.2%, $p = 0.006$). There were no differences in the proportions of patients who achieved MCID for any other PRO measure at 90 days and 1 year between patients who underwent lumbar decompression at ASC versus those

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TABLE 1. Baseline sociodemographic data and comorbid conditions in patients who underwent anterior cervical surgery with same-day discharge in prematched and matched cohorts

	Prematched				Matched (4:1)			
	HOPD	ASC	Combined	p Value	HOPD	ASC	Combined	p Value
No. (%) of cases	933 (82)	211 (18)	1,144 (100)		644 (80)	162 (20)	806 (100)	
Sociodemographic characteristics								
Age, yrs	52.5	52.3	52.4	0.850	51.2	52.0	51.4	0.409
Age group				0.921				0.818
18–64 yrs	85.4	86.3	85.6		88.7	86.4	88.2	
65–69 yrs	7.5	7.1	7.4		5.6	7.4	6.0	
70–74 yrs	4.9	5.7	5.1		4.5	5.6	4.7	
75–79 yrs	1.4	1.0	1.3		0.9	0.6	0.9	
≥80 yrs	0.6	0.0	0.5		0.3	0.0	0.3	
Male sex	54.5	44.1	52.5	0.006	53.3	48.2	52.2	0.244
Race				0.021				0.040
White	89.4	88.2	89.2		90.2	87.7	89.7	
Black	5.1	3.8	4.9		4.8	3.7	4.6	
Other	4.0	8.1	4.7		3.7	8.6	4.7	
Missing	1.5	0.0	1.2		1.2	0.0	1.0	
Education				0.258				0.677
Less than high school	3.1	1.4	2.8		2.5	0.6	2.1	
High school or GED	31.2	31.8	31.3		32.0	34.0	32.4	
2-yr college	15.4	13.7	15.1		14.0	13.6	13.9	
4-yr college	12.3	10.0	11.9		12.6	10.5	12.2	
Postcollege	7.6	5.7	7.3		7.3	6.8	7.2	
Missing	30.3	37.4	31.6		31.7	34.6	32.3	
Private insurance	66.1	75.8	67.9	0.006	70.5	76.5	71.7	0.127
Baseline factors & comorbidities								
Current smoker				0.024				0.159
Yes	18.0	13.3	17.1		16.3	11.7	15.4	
No	61.1	57.8	60.5		62.3	61.1	62.0	
Missing	20.9	28.9	22.4		21.4	27.2	22.6	
BMI, kg/m ²	30.2	28.2	29.8	0.001	29.1	29.1	29.1	0.973
BMI categories				<0.001				0.989
Underweight or normal (<24.9 kg/m ²)	19.6	27.5	21.1		22.8	22.2	22.7	
Overweight (25–29.9 kg/m ²)	34.4	41.7	35.8		37.3	37.7	37.3	
Class I obesity (30–34.9 kg/m ²)	25.2	20.4	24.3		25.0	26.5	25.3	
Class II obesity (35–39.9 kg/m ²)	13.3	8.1	12.3		11.3	10.5	11.2	
Class III obesity (>40 kg/m ²)	7.5	2.4	6.6		3.6	3.1	3.5	
Diabetes	17.2	10.4	15.9	0.016	12.7	12.4	12.7	0.895
Scoliosis	19.8	9.0	17.8	0.001	17.9	8.0	15.9	0.006
DVT	4.6	2.4	4.2	0.096	3.4	1.9	3.1	0.226
CAD	7.3	2.8	6.5	0.009	5.6	3.1	5.1	0.134
Depression	35.7	25.1	33.7	0.003	33.9	24.7	32.0	0.025
Anxiety	37.1	33.7	36.5	0.349	34.2	32.7	33.9	0.728
Hypertension	44.5	28.9	41.6	<0.001	35.6	30.3	34.5	0.204
Osteoporosis	5.4	2.8	4.9	0.082	4.2	1.9	3.7	0.115
CHF	1.1	0.0	0.9	0.129	0.9	0.0	0.7	0.259
COPD	7.5	6.2	7.3	0.498	4.8	6.2	5.1	0.298
Depression on PHQ2 at baseline				<0.001				<0.001
Yes	15.9	19.4	16.5		16.2	22.2	17.4	

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TABLE 1. Baseline sociodemographic data and comorbid conditions in patients who underwent anterior cervical surgery with same-day discharge in prematched and matched cohorts

	Prematched				Matched (4:1)			
	HOPD	ASC	Combined	p Value	HOPD	ASC	Combined	p Value
Baseline factors & comorbidities (continued)								
Depression on PHQ2 at baseline (continued)								
No	60.5	43.6	57.3		59.9	42.6	56.5	
Missing	23.7	37.0	26.1		23.9	35.2	26.2	
Preop daily opioid use				0.038				0.123
Yes	16.9	17.5	17.1		15.1	19.1	15.9	
No	53.1	44.1	51.4		53.9	45.1	52.1	
Missing	30.0	38.4	31.6		31.1	35.8	32.0	
Symptom duration				0.024				0.031
<3 mos	14.8	13.7	14.6		15.7	13.6	15.3	
≥3 mos but <1 yr	33.9	26.5	32.5		34.2	25.3	32.4	
≥1 yr	47.9	52.6	48.8		46.4	53.7	47.9	
Missing	3.4	7.1	4.1		3.7	7.4	4.5	
ASA ≥II	41.8	13.7	36.6	<0.001	18.0	17.9	18.0	0.974
Independent preop ambulation	96.0	99.1	96.6	0.015	97.4	99.4	97.8	0.095
Previous spine surgery	30.8	32.7	31.1	0.582	28.7	35.2	30.0	0.109
Employed at baseline				0.016				0.366
Yes	39.4	39.3	39.4		42.7	42.0	42.6	
No	31.7	23.2	30.2		27.8	23.5	26.9	
Missing	28.8	37.4	30.4		29.5	34.6	30.5	

GED = General Educational Development; PHQ2 = Patient Health Questionnaire-2.
Values are shown as mean or % unless indicated otherwise.

treated at HOPD ($p > 0.05$). Additionally, there were no differences in return to work at 90 days or 1 year between the ASC and HOPD cohorts ($p > 0.05$) (Table 8).

Discussion

Improvements in surgical technique and perioperative care have led to an increasing number of spine surgical procedures that can be performed safely and effectively in an outpatient setting. Same-day discharge for several spine surgical procedures have been shown to be safe, including single- or 2-level ACDF, single or 2-level CDA, and lumbar laminectomy and/or discectomy.²⁻¹⁵ Given this, ASCs have grown as a place of service for spine surgery, although concerns remain about the safety of performing outpatient spine surgery away from the hospital setting.²⁶⁻²⁸ In this study, we found that 1) both outpatient ACDF/CDA and lumbar decompression had similar improvements in PROs and return to work at 90 days and 1 year in ASC and HOPD, with a slightly higher proportion of ASC patients undergoing lumbar decompression reaching MCID for numeric rating scale score for leg pain at 90 days; 2) there was no difference in adverse events in patients who underwent outpatient ACDF/CDA in the ASC setting versus those treated in HOPD, including any complication, readmission at 30 or 90 days, and return to OR; and 3) outpatient lumbar decompression in the ASC

was associated with a slightly higher rate of return to OR, driven primarily by reherniation.

To our knowledge, our study compared the PROs of the largest series of patients who underwent ACDF/CDA or lumbar decompression with same-day discharge at the ASC versus HOPD. We found that patients had similar levels of clinical improvement, as well as return to work, whether the surgery was performed at an ASC or HOPD. Although patients who underwent lumbar decompression at an ASC had a slightly higher rate of MCID of leg pain improvement at 90 days compared to HOPD, all other PRO measures were similar, and these differences did not reach statistical significance at 1 year. Although ACDF, CDA, and lumbar decompression have all been shown to be effective at improving PROs, both in the short term and long term, few studies have directly compared the clinical outcomes of patients who underwent surgery in ASC versus HOPD. Patel et al. conducted a retrospective review of patients who underwent ACDF at ASC with those who underwent surgery at HOPD and found that both cohorts had similar outcomes at 1 year with respect to PROs.⁶ Additionally, they found similar clinical improvement with patients undergoing lumbar microdiscectomy, regardless of surgical setting.³⁰ Vaishnav et al. reported similar findings in their comparison of 2-level ACDF.⁵ While these findings are consistent with ours, these studies by Patel et al. and Vaishnav et al. were limited in that the cases examined

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TABLE 2. Baseline sociodemographic data and comorbid conditions in patients who underwent lumbar decompression with same-day discharge in prematched and matched cohorts

	Prematched				Matched (4:1)			
	HOPD	ASC	Combined	p Value	HOPD	ASC	Combined	p Value
No. (%) of cases	4,591 (87)	675 (13)	5,266 (100)		2,679 (80)	672 (20)	3,351 (100)	
Sociodemographic characteristics								
Age, yrs	53.9	54.9	54.0	0.112	51.3	54.9	52.0	<0.001
Age group				0.009				<0.001
18–64 yrs	71.5	66.1	70.8		77.4	66.2	75.1	
65–69 yrs	10.5	13.3	10.8		9.2	13.2	10.0	
70–74 yrs	8.7	11.1	9.0		6.9	11.0	7.7	
75–79 yrs	5.7	6.8	5.9		4.0	6.9	4.5	
≥80 yrs	3.6	2.7	3.5		2.5	2.7	2.5	
Male sex	57.6	63.1	58.3	0.007	57.5	63.2	58.6	0.006
Race				0.015				0.033
White	87.1	89.5	87.4		86.8	89.4	87.3	
Black	5.7	5.2	5.6		5.6	5.2	5.6	
Other	4.9	4.7	4.9		5.3	4.8	5.2	
Missing	2.3	0.6	2.1		2.3	0.6	1.9	
Education				<0.001				<0.001
Less than high school	2.5	1.8	2.4		2.3	1.8	2.2	
High school or GED	27.5	22.2	26.8		26.8	22.3	25.9	
2-yr college	11.9	10.1	11.6		11.5	10.1	11.2	
4-yr college	12.6	8.2	12.1		13.5	8.2	12.4	
Postcollege	9.7	7.7	9.5		10.3	7.4	9.8	
Missing	35.8	50.1	37.6		35.5	50.2	38.5	
Private insurance	61.1	67.1	61.9	0.003	66.3	67.4	66.5	0.583
Baseline factors & comorbidities								
Current smoker				<0.001				<0.001
Yes	14.5	8.7	13.8		14.3	8.6	13.1	
No	63.6	52.4	62.1		63.1	52.5	60.9	
Missing	21.9	38.8	24.1		22.7	38.8	25.9	
BMI, kg/m ²	30.4	29.4	30.3	<0.001	29.8	29.4	29.7	0.133
BMI categories				0.002				0.658
Underweight or normal (<24.9 kg/m ²)	18.4	22.4	18.9		20.9	22.3	21.2	
Overweight (25–29.9 kg/m ²)	35.1	38.1	35.5		36.5	38.1	36.8	
Class I obesity (30–34.9 kg/m ²)	25.6	24.3	25.4		25.3	24.3	25.1	
Class II obesity (35–39.9 kg/m ²)	13.5	10.7	13.1		12.4	10.7	12.0	
Class III obesity (≥40 kg/m ²)	7.4	4.6	7.0		5.0	4.6	4.9	
Diabetes	17.5	11.7	16.7	<0.001	12.4	11.8	12.2	0.672
Scoliosis	30.7	16.6	28.9	<0.001	29.1	16.5	26.6	<0.001
DVT	4.6	1.2	4.1	<0.001	3.6	1.2	3.1	0.001
CAD	10.4	6.2	9.9	0.001	5.6	6.3	5.7	0.491
Depression	29.3	13.9	27.3	<0.001	26.8	14.0	24.2	<0.001
Anxiety	31.3	18.4	29.6	<0.001	30.2	18.3	27.8	<0.001
Hypertension	47.0	36.3	45.7	<0.001	39.3	36.3	38.7	0.154
Osteoporosis	8.4	3.7	7.8	<0.001	6.9	3.7	6.3	0.002
CHF	2.0	0.7	1.9	0.010	1.2	0.7	1.1	0.353
COPD	7.1	2.4	6.5	<0.001	4.3	2.4	3.9	0.020
Depression on PHQ2 at baseline				<0.001				<0.001
Yes	16.4	15.6	16.3		15.4	15.5	15.4	

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TABLE 2. Baseline sociodemographic data and comorbid conditions in patients who underwent lumbar decompression with same-day discharge in prematched and matched cohorts

	Prematched				Matched (4:1)			
	HOPD	ASC	Combined	p Value	HOPD	ASC	Combined	p Value
Baseline factors & comorbidities (continued)								
Depression on PHQ2 at baseline (continued)								
No	52.7	35.0	50.4		53.5	35.0	49.8	
Missing	30.9	49.5	33.3		31.1	49.6	34.8	
Preop daily opioid use				<0.001				<0.001
Yes	19.3	12.3	18.4		17.8	12.4	16.7	
No	49.2	37.2	47.7		50.5	37.1	47.8	
Missing	31.5	50.5	33.9		31.7	50.6	35.5	
Symptom duration				<0.001				<0.001
<3 mos	16.0	18.5	16.4		16.6	18.6	17.0	
≥3 mos but <1 yr	33.8	29.0	33.2		34.7	29.0	33.6	
≥1 yr	47.9	45.9	47.7		46.9	45.8	46.7	
Missing	2.2	6.5	2.8		1.8	6.6	2.7	
ASA >II	39.5	16.4	36.6	<0.001	16.6	16.5	16.6	0.972
Independent preop ambulation	87.6	89.3	87.8	0.200	89.7	89.3	89.6	0.776
Previous spine surgery	27.1	23.1	26.6	0.010	24.5	22.9	24.2	0.602
Employed at baseline				<0.001				<0.001
Yes	33.3	22.7	31.9		36.6	22.8	33.8	
No	35.9	27.4	34.8		32.3	27.2	31.3	
Missing	30.8	49.9	33.3		31.1	50.0	34.9	

Values are shown as mean or % unless indicated otherwise.

were poorly controlled for same-day discharge and did not include matched patient cohorts, which limited the strength of comparability. Both studies were also single-surgeon series, limiting their applicability in a wider cohort. Patel and colleagues conducted a matched retrospective comparison of 117 patients who underwent outpatient CDA in ASC versus HOPD and found that both cohorts had similar levels of clinical improvement, consistent with our findings.³

Some authors have questioned the safety of performing anterior cervical surgery in an ASC, outside of a hospital setting.^{26,27} Although many authors have shown that outpatient anterior cervical surgery is safe, including in comparison to inpatient surgery, few previous studies have performed direct, matched comparisons between same-day discharges in ASC and HOPD settings to refute the claims of critics of ASCs.^{4,7,8,11,12,34,34} This is most likely the

TABLE 3. Baseline PRO measures in patients who underwent lumbar decompression or anterior cervical arthrodesis/arthroplasty with same-day discharge before and after matching, separated by ASC and HOPD

	Prematched				Matched (4:1)			
	HOPD	ASC	Combined	p Value	HOPD	ASC	Combined	p Value
Lumbar decompression								
PROMIS Function score	35.4 (3077)	34.9 (340)	35.3 (3417)	0.217	35.5 (1779)	34.9 (338)	35.4 (2117)	0.081
EQ-5D	0.55 (2728)	0.53 (283)	0.55 (3011)	0.183	0.55 (1569)	0.53 (282)	0.55 (1851)	0.181
Back pain	6.30 (3041)	6.51 (328)	6.32 (3369)	0.194	6.22 (1775)	6.52 (327)	6.26 (2102)	0.065
Leg pain	6.68 (3044)	6.84 (329)	6.70 (3373)	0.284	6.68 (1784)	6.84 (328)	6.70 (2112)	0.288
Anterior cervical 1 or 2 levels								
PROMIS Function score	41.1 (650)	40.6 (131)	41.0 (781)	0.462	41.6 (443)	40.2 (105)	41.3 (548)	0.086
EQ-5D	0.62 (582)	0.59 (113)	0.62 (695)	0.185	0.63 (398)	0.57 (91)	0.62 (489)	0.014
Neck pain	6.2 (629)	6.7 (131)	6.3 (760)	0.056	6.1 (423)	6.7 (105)	6.2 (528)	0.023
Arm pain	5.6 (622)	6.2 (129)	5.7 (751)	0.015	5.5 (420)	6.2 (103)	5.7 (523)	0.033

Values are shown as mean score (no. of patients completing the PRO measure) unless indicated otherwise.

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TABLE 4. Surgical characteristics for lumbar decompression and anterior cervical surgery with same-day discharge, before and after matching

	Prematched				Matched (4:1)			
	HOPD	ASC	Combined	p Value	HOPD	ASC	Combined	p Value
Lumbar decompression								
Laminectomy (only)	32.9	37.6	33.5	0.014	29.5	37.4	31.1	<0.001
Discectomy (only)	4.3	4.7	4.4	0.345	5.0	4.8	4.9	0.828
Laminectomy & discectomy	61.8	57.6	61.2	0.039	65.6	57.9	64.0	<0.001
No. of levels				0.193				0.492
1	69.2	68.4	69.1		70.9	68.8	70.5	
2	24.6	24.4	24.5		23.6	24.6	23.8	
3	4.5	6.5	4.8		4.8	6.1	5.1	
≥4	0.6	0.6	0.6		0.7	0.6	0.7	
Missing	1.1	0.0	0.9					
Length of surgery, mins	69.3	46.3	66.3	<0.001	68.5	46.2	64.0	<0.001
Estimated blood loss, ml	26.5	28.7	26.7	0.355	25.6	28.8	26.0	0.333
Ambulation w/in 8 hrs				<0.001				<0.001
Yes	70.2	84.0	72.0		71.4	83.9	73.9	
No	26.4	13.2	24.7		25.7	13.2	23.2	
Missing	3.4	2.8	3.3		2.9	2.8	2.9	
Discharge to home	99.9	100.0	99.9	0.503	99.9	100.0	99.9	0.511
Anterior cervical 1 or 2 levels								
Arthroplasty	15.5	28.0	17.8	<0.0001	17.7	29.6	20.1	0.001
No. of levels				0.700				0.418
1	65.0	66.4	65.2		67.6	64.2	66.9	
2	35.1	33.7	34.8		32.5	35.8	33.1	
Missing								
Length of surgery, mins	77.8	61.3	74.8	<0.001	78.1	61.9	74.8	<0.001
Estimated blood loss, ml	27.5	18.1	26.3	<0.001	26.6	18.7	25.5	<0.001
Ambulation w/in 8 hrs				<0.001				<0.001
Yes	74.9	92.9	78.2		78.0	92.6	80.9	
No	24.1	7.1	21.0		21.4	7.4	18.6	
Missing	1.0	0.0	0.8		0.6	0.0	0.5	
Discharge to home	99.8	100.0	99.8	0.665	99.8	100.0	99.9	0.799

Values are shown as mean or % unless indicated otherwise.

result of a high prevalence of single-surgeon series in the literature, in which patients who are candidates for same-day discharges are all treated in the ASC setting, without a strong comparison group in the HOPD. In our study, we found that ACDF and CDA with same-day discharge was just as safe in an ASC as HOPD, with no difference in any complication, readmission at 30 or 90 days, ED visits, or return to OR between matched patient cohorts. Gornet and colleagues compared the safety of single- and 2-level CDA performed in the ASC versus HOPD and found that there was no difference in complications between ASC and outpatient hospital patients. Notably, Gornet et al. did not control these two cohorts for same-day discharge, including patients who had an overnight stay in the HOPD cohort.² To our knowledge, our study is one of the only studies that shows the safety of anterior cervical surgery in ASC, when compared to a matched patient cohort of same-day discharge in HOPD.

In our study, we found that lumbar decompression with same-day discharge performed in ASC was associated with a higher rate of return to the OR compared to HOPD. This difference in reoperation was driven primarily by a statistically higher rate of lumbar disc reherniation in the ASC group compared to the HOPD group (3.27% vs 1.01%, respectively) and not due to medical complications. There was no difference in any other adverse event between the ASC and HOPD groups, including readmission at 30 or 90 days, surgical site infection, and ED visit. In contrast to our findings, Malik et al. compared 90-day complications between matched cohorts of patients who underwent lumbar decompression with same-day discharge at HOPD versus ASC and found no difference in cohorts with respect to any complications, including return to OR and reherniation.³⁵ Other authors have similarly found no difference in return to OR or reherniation in HOPD and ASC cohorts after outpatient lumbar decompression.^{33,36} We believe that

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TABLE 5. Postoperative adverse events in patients who underwent lumbar decompression and anterior cervical surgery with same-day discharge, before and after cohort matching

	Prematched				Matched (4:1)			
	HOPD	ASC	Combined	p Value	HOPD	ASC	Combined	p Value
Lumbar decompression								
Any complication	5.6	8.0	5.9	0.014	5.5	8.0	6.0	0.011
Urinary retention	0.4	0.2	0.4	0.279	0.3	0.2	0.3	0.374
Readmission								
30 days	2.1	2.4	2.2	0.375	2.1	2.4	2.2	0.688
90 days	3.6	3.9	3.7	0.424	3.6	3.9	3.6	0.688
SSI	0.9	1.5	1.0	0.133	0.8	1.5	1.0	0.112
Return to OR	2.1	4.9	2.5	<0.001	2.1	4.9	2.7	<0.001
ED visit	9.0	8.3	8.9	0.539	7.9	8.2	8.0	0.816
Ileus	0.1	0.0	0.1	0.663	0.1	0.0	0.1	0.639
Anterior cervical 1 or 2 levels								
Any complication	4.1	4.3	4.1	0.511	3.7	5.6	4.1	0.200
Urinary retention	0.2	0.0	0.2	0.665	0.2	0.0	0.1	0.799
Readmission								
30 days	1.5	1.0	1.4	0.411	1.2	1.2	1.2	0.675
90 days	2.5	1.0	2.2	0.132	2.0	1.2	1.9	0.392
SSI	0.4	1.0	0.5	0.306	0.5	1.2	0.6	0.265
Return to OR	1.1	1.4	1.1	0.440	0.9	1.9	1.1	0.264
ED visit	9.0	8.5	8.9	0.828	8.1	9.9	8.4	0.461
Ileus								
Dysphagia	0.8	1.9	1.0	0.128	0.8	2.5	1.1	0.148

Boldface type indicates statistical significance ($p < 0.05$).

although our ASC and HOPD cohorts underwent matching of their baseline characteristics, followed by multivariate regression, ASC patients may still be biased toward more/earlier activity, whether that is secondary to intrinsic patient factors, or to perioperative management in ASC (anesthesia/ERAS [enhanced recovery after surgery] protocols, expedited home discharge, etc.). Alternatively, our observed difference could also be related to sampling bias because rates for both ASC and HOPD fell well within the reported rates of lumbar disc reherniation.³⁷

Our study had several limitations to be considered. First of all, potential biases, including selection bias, ex-

TABLE 6. Summary of multivariate regression analysis of adverse events in lumbar decompression performed in ASC compared to HOPD

Adverse Events	No.	IRR	p Value
Any complication	3,333	1.50	0.001
Return to OR	3,333	2.30	<0.001
30-day readmission	3,333	0.97	0.885
90-day readmission	3,333	0.97	0.887
ED visit	3,333	1.14	0.664
SSI	2,917	2.28	0.066

Boldface type indicates statistical significance ($p < 0.05$).

TABLE 7. Reasons for return to OR for patients who underwent lumbar decompression, separated by facility

	Lumbar Decompression	
	HOPD (n = 2,679)	ASC (n = 672)
Patients w/ return to OR	56	33
1 return	46	27
2 returns	9	4
3 returns	1	2
Total return to OR occurrences	67	41
Return to OR reasons		
Hematoma	9 (0.3)	4 (0.6)
CSF leak	9 (0.3)	2 (0.3)
I & D, infection, exploration	17 (0.6)	7 (1.0)
Wound dehiscence	3 (0.1)	0 (0.0)
Recurrent disc herniation	27 (1.0)	22 (3.2)
Hardware failure	0 (0.0)	1 (0.1)
Other	9 (0.3)	1 (0.1)
Pain	3 (0.1)	3 (0.4)
Residual compression	3 (0.1)	1 (0.1)
Seroma	6 (0.2)	3 (0.4)

I & D = incision and drainage.

Values are shown as number or number (%).

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TABLE 8. Postoperative PROs in the matched cohorts who underwent anterior cervical surgery or lumbar decompression surgery with same-day discharge, including MCID

	Anterior Cervical 1 or 2 Levels				Lumbar Decompression			
	HOPD	ASC	Combined	p Value	HOPD	ASC	Combined	p Value
MCID for PROMIS score								
90 days	58.4 (153/262)	65.6 (42/64)	59.8 (195/326)	0.290	75.1 (826/1100)	78.3 (170/217)	75.6 (996/1317)	0.308
% of all patients	40.68	39.5	40.45		41.06	32.29	39.30	
1 yr	67.6 (100/148)	63.2 (24/38)	66.7 (124/186)	0.607	74.9 (474/633)	68.5 (74/108)	74.0 (548/741)	0.164
% of all patients	22.98	23.46	23.08		23.63	16.07	22.11	
Patient satisfaction								
90 days	89.5 (339/379)	87.1 (74/85)	89.0 (413/464)	0.525	88.4 (1346/1523)	88.0 (278/316)	88.3 (1624/1839)	0.839
% of all patients	58.85	52.47	57.57		56.85	47.02	54.88	
1 yr	90.3 (195/216)	83.0 (39/47)	89.0 (234/263)	0.119	84.7 (772/911)	89.1 (163/183)	85.5 (935/1094)	0.129
% of all patients	33.5	29.01	32.63		34.01	27.23	32.65	
MCID for EQ-5D score								
90 days	59.2 (135/228)	53.9 (28/52)	58.2 (163/280)	0.479	64.9 (565/870)	61.4 (94/153)	64.4 (659/1023)	0.404
% of all patients	35.40	32.1	34.74		32.47	22.77	30.53	
1 yr	61.6 (77/125)	53.6 (15/28)	60.1 (92/153)	0.433	64.7 (322/498)	57.7 (49/85)	63.6 (371/583)	0.214
% of all patients	19.40	17.28	18.98		18.59	12.65	17.40	
MCID for neck/back pain								
90 days	66.5 (169/254)	68.2 (45/66)	66.9 (214/320)	0.800	76.3 (797/1044)	82.5 (165/200)	77.3 (962/1244)	0.057
% of all patients	39.44	40.74	39.7		38.97	29.76	37.12	
1 yr	65.9 (89/135)	55.0 (22/40)	63.4 (111/175)	0.208	72.3 (422/584)	75.0 (75/100)	72.7 (497/684)	0.570
% of all patients	20.96	24.69	21.71		21.80	14.88	20.41	
MCID for arm/leg pain								
90 days	74.2 (167/225)	64.1 (41/64)	72.0 (208/289)	0.110	81.5 (877/1076)	86.1 (179/208)	82.2 (1056/1284)	0.006
% of all patients	34.94	39.51	35.86		40.28	30.95	38.32	
1 yr	79.0 (98/124)	67.5 (27/40)	76.2 (125/164)	0.136	79.1 (468/592)	78.8 (78/99)	79.0 (546/691)	0.952
% of all patients	19.256	24.69	20.35		22.1	14.73	20.62	
Return to work								
90 days	77.0 (144/187)	80.4 (41/51)	77.7 (185/238)	0.606	78.0 (557/714)	77.6 (83/107)	78.0 (640/821)	0.918
% of all patients	29.04	31.48	29.53		26.65	15.92	24.50	
1 yr	90.7 (98/108)	86.2 (25/29)	89.8 (123/137)	0.339	84.8 (357/421)	77.4 (41/53)	84.0 (398/474)	0.164
% of all patients	16.77	17.90	17		15.71	7.89	14.14	

Values are shown as % (no. of patients achieving MCID/total no. of patients with completed PRO) unless indicated otherwise. Boldface type indicates statistical significance ($p < 0.05$).

ist with a retrospective study. We attempted to control for these by utilizing stringent inclusion and exclusion criteria, as well as by utilizing consecutive cases over a specific period of time in a prospectively maintained, spine-specific, statewide database that included a variety of practice environments in order to improve the generalizability of our results. Additionally, we employed a propensity-matched design to bring homogeneity to the comparative cohorts to further mitigate biases associated with a retrospective design. However, alternative designs, such as a prospective, randomized trial, may help bring a higher level of evidence with a lower risk of bias. Additionally, we had large numbers of patients who did not report PROs or did not have certain information available (e.g., employment data). In this situation, because these categories were our secondary outcome measures, we only included patients who had data available when analyzing that category, and as such

we may have introduced selection and/or response bias. Multiple imputations were not used for the missing PROs because multiple imputation for outcomes is not generally recommended, unless we believe that the outcomes are not missing at random (for which we did not have evidence) or we have access to an auxiliary complete variable that is not already part of the model but highly correlated to outcomes and could help predicting missingness (which we did not have evidence for either). Additionally, our study had some limitations related to the granularity of the data available, given that it was database study (e.g., with exact diagnosis and preoperative imaging characteristics available) and may have missed complications that did not fall in a specific adverse outcome category (e.g., reherniation that did not require return to OR). In addition, specific surgeon or surgical technique could not be analyzed and could have influenced outcome. Overall, we feel

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that MSSIC has richer and more detailed data available compared to larger claims-based studies, but regardless, these limitations exist. Finally, as with all database studies, while large patient cohorts allow us to detect small statistical differences between groups, these differences may not always be clinically significant.

Although outside the scope of our study, there has been an increased emphasis on cost-effectiveness and value within healthcare, given the ballooning costs associated with healthcare delivery in an aging population in the US. Outpatient lumbar decompression in ASC has been shown not only to have a lower cost at the time of service but also lower postoperative resource utilization, leading to more than double the cost-effectiveness compared to the same procedure performed in the HOPD.^{35,36,38} Because of the differences in methodology to calculate payments in ASC versus HOPD, the typical payment from payer to ASC is approximately 48% of that of HOPD for the same procedure.^{22,39} This, in turn, leads to a more cost-effective episode of care in ASC.

Conclusions

We performed a retrospective, propensity-matched, comparative cohort analysis of a statewide, prospective, multicenter, spine-specific database of patients who underwent ACDF, CDA, or lumbar decompression in ASC versus HOPD with same-day discharge. We found that ACDF, CDA, and lumbar decompression had similar complication rates and clinical outcomes in ASC compared to HOPD. Overall, our study is most helpful at adding to the growing body of literature showing the safety of outpatient spine surgery performed in the ASC. More specifically, our data suggest that there are no advantages from a safety or clinical outcome standpoint to performing ACDF, CDA, or lumbar decompression in HOPD compared to ASC if a patient is a candidate for same-day discharge. As such, future studies should focus on improving the value of outpatient spine surgery from a cost-effectiveness standpoint, as well as improving the ability to better identify patients who are more likely to require hospital admission after spine surgery.

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Attachment 12

Purpose of the Project

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Disclaimer

Although BCBSM and MSSIC work collaboratively, the opinions, beliefs, and viewpoints expressed by the authors do not necessarily reflect the opinions, beliefs, and viewpoints of BCBSM or any of its employees.

Disclosures

D. Park reported personal fees from Stryker, Kuros, Medynus, and Arthrex; and grants from Orthofix outside the submitted work. V. Chang reported grants from Blue Cross Blue Shield; and personal fees from Globus Medical, Bioventus, and VISEON outside the submitted work. I. Aleem reported personal fees from Globus, Orthofix, and Kuros outside the submitted work. M. Abdulhak reported consultant and royalty fees from Orthofix SeaSpine, royalty fees from Ulrich Medical USA, and consultant fees from Spinal Elements outside the submitted work. M. Perez-Cruet reported stock ownership of Thompson MIS/Bonebac. J. Khalil reported grants from Abbott, Centinel Spine, Highridge, Globus, Medtronic, Boston Scientific, SI-BONE, Stryker, VB Spine, Fziomed, Limflex, and Synergy Spine; and personal fees from Evolution Spine, Abbott, Centinel Spine, Highridge, Globus, Medtronic, Boston Scientific, SI-BONE, Stryker, and VB Spine outside the submitted work.

Author Contributions

Conception and design: Park, Zakko, Nerenz, Kazemi, Taliaferro, Khalil. Acquisition of data: Park, Hu, Zakko, Nerenz, Taliaferro, Easton. Analysis and interpretation of data: Gandhi, Park, Hu, Zakko, Schultz, Aleem, Kazemi, Abdulhak, Perez-Cruet, Khalil. Drafting the article: Gandhi, Park, Zakko, Schultz, Taliaferro, Perez-Cruet, Khalil. Critically revising the article: Gandhi, Park, Zakko, Tong, Schultz, Chang, Nerenz, Aleem, Kazemi, Taliaferro, Easton, Perez-Cruet, Khalil. Reviewed submitted version of manuscript: Gandhi, Park, Hu, Zakko, Chang, Aleem, Kazemi, Taliaferro, Abdulhak, Easton, Perez-Cruet, Khalil. Approved the final version of the manuscript on behalf of all authors: Gandhi. Statistical analysis: Park, Hu, Schultz. Administrative/technical/material support: Nerenz, Easton. Study supervision: Zakko, Taliaferro, Perez-Cruet.

Correspondence

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Attachment 13

Alternatives of the Project

The Applicant explored several alternatives before submitting this application to the Illinois Health Facilities and Services Review Board seeking approval to expand the existing Orthollinois Surgery Center Elgin, LLC through the addition of two operating rooms. Among other options, the Applicant considered maintaining the status quo, utilizing hospital-based facilities, utilizing a smaller expansion, or the Project as Proposed. For the reasons stated below, Applicant opted to seek the Project as Proposed.

Alternative #1: Maintain the Status Quo (No additional Cost)

The Applicant considered continuing operations within the existing physical plant without expanding operating room capacity. Under this alternative, Orthollinois Surgery Center Elgin would continue to provide outpatient orthopedic, podiatric, pain management, and related surgical services utilizing its current operating room inventory.

This alternative was determined to be suboptimal because it would not adequately address the increasing demand for outpatient musculoskeletal and spine-related procedures within the service area. Advances in surgical techniques, anesthesia protocols, and postoperative care continue to shift procedures from inpatient and hospital outpatient settings into ambulatory surgery centers. As a result, demand for operating room time continues to grow. Maintaining the status quo would constrain scheduling flexibility, limit the facility's ability to accommodate additional physicians and patients, and may result in longer wait times for elective procedures. In addition, failing to expand capacity would limit the Applicant's ability to continue providing care in a coordinated and efficient manner at a single location specifically designed for outpatient surgical services. Currently, providers at Orthollinois Surgery Center Elgin provide services to their patients at other facilities due to excess demand at the ASTC. Increasing the capacity at this location will reduce patient and provider need to travel across multiple locations and improve continuity of care.

Accordingly, maintaining the status quo would not adequately address the identified need for increased outpatient surgical capacity within the Elgin service area.

Alternative #2: Utilize Hospital-Based Surgical Facilities

The Applicant also considered directing additional procedure volume to hospital-based operating rooms rather than expanding the existing ASTC.

This alternative was rejected for several reasons. Hospital-based procedures are generally associated with higher facility costs than procedures provided in ambulatory surgery centers. Research has consistently demonstrated that orthopedic and spine procedures performed in ambulatory surgery centers result in lower facility costs, lower payer expenditures, and lower patient out-of-pocket expenses than comparable procedures performed in hospital outpatient departments. Hospital operating room capacity is a shared community resource. Area hospitals serve a broad range of surgical specialties and patient populations, and their operating room schedules must accommodate emergency, trauma, and inpatient surgical cases in addition to outpatient procedures. Directing incremental outpatient orthopedic volume to hospital facilities when those cases can be safely and effectively performed in an ASTC would consume hospital capacity that could otherwise be allocated to higher-acuity patients who require the full resources of a hospital setting. This is particularly relevant given that Orthollinois physicians serve as key providers at area trauma centers, including Advocate Sherman Hospital, and the practice's strong hospital partnerships are enhanced not diminished when ASTC-appropriate cases are performed in the appropriate ambulatory setting.

The procedures provided by Orthollinois are generally well-suited for an ambulatory setting and often do not require the resources associated with an inpatient hospital environment. Consequently, reliance upon hospital-based surgical facilities would not provide the same level of accessibility, efficiency, or cost-effectiveness as the proposed project.

Attachment 13

Alternatives of the Project

Alternative #3- Expand an Existing ASTC by One Operating Room

A one-operating-room expansion would not provide sufficient scheduling flexibility to accommodate anticipated procedure growth, additional physician utilization, and increasing patient demand over the long term. In addition, constructing only one operating room would not achieve meaningful economies of scale in construction, design, and infrastructure costs. The project involves the buildout of a 9,951 gross-square-foot addition, and the marginal cost of constructing a second operating room within that footprint is substantially lower than the cost of undertaking a separate future construction project to add a second room at a later date. Phasing the expansion would result in higher total project costs, additional disruption to ongoing facility operations, and a second regulatory review cycle. For these reasons, the one-room alternative was rejected in favor of the proposed two-room expansion.

As a result, this alternative would not achieve the level of integration, access, or efficiency necessary to meet community needs.

Alternative #4: Project as Proposed

The Applicant carefully evaluated each alternative and determined that the proposed expansion of Orthollinois Surgery Center Elgin through the addition of two operating rooms represents the most appropriate and cost-effective solution for addressing the service area's current and anticipated needs.

The proposed project will expand the facility's capacity to provide orthopedic surgery, podiatric surgery, pain management procedures, and outpatient spine procedures in a dedicated ambulatory setting. Expanding the existing ASTC allows the Applicant to leverage an established facility, existing infrastructure, experienced clinical personnel, and proven operational systems, thereby maximizing efficiency while minimizing unnecessary expenditures. The project will improve patient access by increasing operating room availability, reducing scheduling constraints, and supporting continued growth in outpatient surgical services.

In addition, the project allows Orthollinois to continue delivering coordinated, patient-centered care in a specialized outpatient environment that has been designed specifically for ambulatory surgical services. Compared to the alternatives considered, the proposed project provides the greatest opportunity to enhance access, maintain high-quality clinical outcomes, improve operational efficiency, and deliver care in a cost-effective manner. Accordingly, the Applicant determined that the Project as Proposed is the alternative that best serves the needs of patients within the service area.

Attachment 14

Size of the Project

The square footage identified in this application for the proposed projects, includes expanding the existing facility by adding two operating rooms, is necessary, not excessive, and consistent with the standards identified in Appendix B of 77 Illinois Admin. Code Section 1110, as documented below.

SIZE OF PROJECT				
DEPARTMENT/SERVICE	PROPOSED BGSF/DGSF	STATE STANDARD	DIFFERENCE	MET STANDARD?
ASTC	5,400	5,400 GSF	0	YES

Attachment 15

Project Service Utilization

The projected utilization for the two additional operating rooms is based on documented historical utilization data maintained by Orthollinois Surgery Center of Elgin ("OISC-E"). During the trailing 12-month period, OISC-E performed 3,860 surgical procedures in its existing four operating rooms.

Actual operating room time data for the facility's operating room records document an average of 42 to 45 minutes of preparation and turnover time per case, which includes patient positioning, room setup, anesthesia preparation, post-procedure cleaning, and instrument turnover. Including preparation and turnover, the average total clinical encounter time per case is approximately 117.6 minutes (1.96 hours).

Applying the documented average total encounter time of approximately 1.96 hours per case to the historical baseline of 3,860 cases results in total facility utilization of approximately 7,566 hours during the last 12 months. Based on an operational schedule of 250 days per year and 7.5 hours of operation per day, each operating room provides 1,875 available procedure hours annually, and the facility's four operating rooms provide a combined total of 7,500 available procedure hours.

The facility's actual utilization of 7,566 hours exceeds the total available capacity of 7,500 hours. On a per-room basis, the existing four operating rooms each averaged approximately 1,891.5 hours of utilization, often necessitating weekend hours to accommodate the additional case load. The State standard requires utilization of at least 1,500 hours per operating room for four rooms, or 6,000 combined hours; the facility's actual utilization of 7,566 hours exceeds that threshold by 1,566 hours, or approximately 26.1%. This results in a current operating room deficit of approximately 2 operating rooms and demonstrates that the existing four-room facility is not merely meeting the State's utilization standards it is operating well above sustainable capacity.

The Applicant's utilization projections for the two additional operating rooms are based on conservative assumptions applied to the documented historical baseline.

At the documented average encounter time of approximately 1.96 hours per case, total projected facility utilization in Year 1 is approximately 7,566 hours, requiring approximately 6 operating rooms. This conservative projection does not account for any growth in patient volume for the facility in year 1. The two additional rooms will absorb the excess demand that cannot be accommodated by the existing four rooms, resulting in projected utilization of approximately 1,566 hours across the two new rooms in Year 1.

Applying a conservative estimate of 5% annual growth in total surgical volume which is consistent with national trends in outpatient orthopedic surgery migration and the practice's historical growth trajectory total, Orthollinois surgical volume is projected to increase from 7,105 to 7,460 procedures in year 2 with OISC-E projected to perform approximately 4,053 cases. Total projected facility utilization in Year 2 is approximately 7,944 hours, requiring approximately 5.30 operating rooms. The two additional rooms are projected to achieve utilization of approximately 1,944 hours in Year 2. Both Year 1 and Year 2 projected utilization for the two additional operating rooms exceeds the State standard of 1,500 hours per operating room.

The facility's historical performance substantially exceeds the projections submitted in the Applicant's original Certificate of Need application (Project #20-040) for the establishment of OISC-E. That application was approved by the Board on December 21, 2021, and the facility opened for operations at the end of 2023. Within approximately two and a half years of opening, the facility has significantly surpassed the utilization levels projected in its original application. In the original application, the Applicant projected 2,744 procedures in Year 1 and 2,881 procedures in Year 2, with utilization of 81% and 86%, respectively, against the State standard of greater than 4,500 combined hours for four operating rooms. The facility's actual trailing twelve-month volume of 3,860 procedures exceeds the original Year 2 projection by approximately 34%. Actual utilization of approximately 7,566 hours far exceeds the original projected utilization of approximately 2,699 hours in Year 1 and 2,835 hours in Year 2.

This performance history demonstrates that OrthoIllinois' utilization projections are conservative and grounded in actual patient demand. The fact that the facility has exceeded its original projections by a substantial margin and is now operating above the capacity of its approved four operating rooms validates both the original need determination and the current need for expansion

Attachment 16 Unfinished or Shell Space

NOT APPLICABLE- The proposed project does not include plans for shell space.

Attachment 17 Assurances

NOT APPLICABLE- The proposed project does not include plans for shell space.

Attachment 24

Non-Hospital Based Ambulatory Services to GSA Residents - 1110.235(C)(2)(B)

The proposed project is necessary to meet the needs of the residents of the planning area as noted in this application. The project involves expanding the existing ASTC located at 2440 Alft Lane, Elgin, Illinois by adding two operating rooms in Kane County. These multi-specialty operating rooms will have ample capacity to meet the needs of patients in the area. The ASTC proposes adding two operating rooms, which will provide sufficient capacity to meet current and projected demand without creating unnecessary duplication of services.

The primary purpose of this project is to provide necessary health care to residents of the geographic service area ("GSA") in which the ASTC will be located. Listed in the following pages, in accordance with 77 Ill. Admin. Code §1110.235(c)(2)(B), is the GSA consisting of all zip codes that are located within a 10-mile radius of the proposed site of the ASTC. We have also included a map of the multidirectional travel radii of the proposed ASTC site.

The facility's geographic service area is identical to the GSA established in the Applicant's original Certificate of Need application (Project #20-040), which was approved by the Illinois Health Facilities and Services Review Board on December 21, 2021. Because the proposed expansion will occur at the same site the 10-mile radius and the corresponding zip code areas that comprise the GSA remain unchanged. The GSA encompasses communities throughout Kane County and portions of McHenry, DeKalb, and Cook counties, including Algonquin, Bartlett, Crystal Lake, Dundee, Elgin, Gilberts, Hampshire, Hoffman Estates, Huntley, Lake in the Hills, Marengo, Pingree Grove, Sleepy Hollow, South Elgin, and Wayne, among others.

Patient origin data for the trailing twelve-month period from July 2025 through June 2026 confirms that the overwhelming majority of patients served at OISC-E reside within the GSA, well in excess of the 50% threshold required under 77 Ill. Admin. Code §1110.235(c)(2)(B). During this period, Orthollinois physicians performed a total of 7,105 surgical procedures across all settings, with patient origin data available by zip code of patient residence. Of the 7,108 procedures for which zip code data was available, the top zip codes by surgical volume were as follows:

Zip Code	Community	Surgical Volume
60142	Huntley	714
60014	Crystal Lake	663
60102	Algonquin	440
60123	Elgin	422
60156	Lake in the Hills	381
60098	Woodstock	339
60124	Elgin	296
60110	Carpentersville	281
60140	Hampshire	278
60120	Elgin	265
60050	McHenry	253
60118	Dundee	211
60152	Lake in the Hills	192
60013	Cary	173
60051	McHenry	166
60177	South Elgin	153
60012	Crystal Lake	152

60097	West Dundee	105
60136	Gilberts	97
60010	Barrington/Bartlett	75

Each of the top twenty zip codes listed above is located within the established GSA. The twenty largest GSA zip codes alone account for 5,656 of the 7,108 total procedures, or approximately 79.6% of total surgical volume.

This patient origin distribution substantially exceeds the 50% GSA residency threshold required under the applicable regulations. The concentration of patient volume in GSA zip codes confirms that the primary purpose of the facility and of the proposed expansion is to provide necessary health care to residents of the geographic service area in which OISC-E is located.

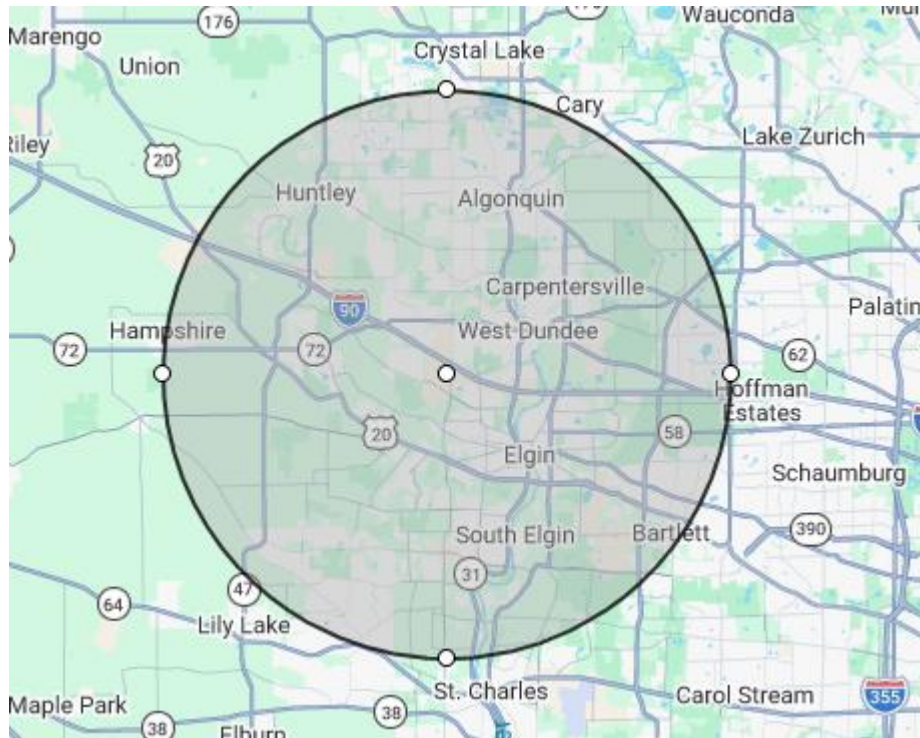
The continued concentration of patient volume within the GSA even as the facility's total case volume has grown from the originally projected 2,744 cases to 3,860 actual cases demonstrates that the growth in demand is being driven by the residents of the geographic service area, and that the proposed expansion will serve the same patient population that the facility was originally established to serve.

A complete listing of patient origin by zip code for all OISC-E admissions during the trailing twelve-month period of July 2025 through June 2026 is included as an attachment to this application, verifying that at least 50% of admissions were residents of the GSA based upon each patient's legal residence for the six months immediately prior to admission.

Listed in the following pages, in accordance with 77 Ill. Admin. Code §1110.235(c)(2)(B), is the GSA consisting of all zip codes that are located within a 10-mile radius of the proposed site of the ASTC. We have also included a map of the multidirectional travel radii of the proposed ASTC site.

ATTACHMENT 24
Non-Hospital Based Ambulatory Services to GSA Residents -
1110.235(C)(2)(B)

10-Mile Radius from 2440 Aft Lane, Elgin, IL 60124



ATTACHMENT 24
Non-Hospital Based Ambulatory Services to GSA Residents -
1110.235(C)(2)(B)

C

Zip Code	City	Estimated Population
60124	Elgin	24,859
60136	Gilberts	8,497
60123	Elgin	47,932
60140	Hampshire	21,902
60177	South Elgin	24,361
60175	St. Charles	26,024
60109	Burlington	580
60183	Wasco	71
60118	Dundee	16,342
60110	Carpentersville	38,762
60120	Elgin	50,799
60142	Huntley	29,831
60102	Algonquin	31,959
60174	St. Charles	30,958
TOTAL		352,877

ATTACHMENT 24

Service Demand – Expansion of Existing ASTC Service 1110.235(c)(4)

The Applicant submits that the proposed expansion of Orthollinois Surgery Center of Elgin, LLC ("OISC-E") is necessary to reduce the facility's experienced high utilization and to meet projected demand for orthopedic, pain management, and podiatric surgical services. Demand for the proposed expansion is demonstrated through documented historical utilization data, physician referral patterns, and conservative projections based on established caseloads, all of which originate primarily from within the Geographic Service Area ("GSA"). These projections are limited to orthopedic surgery, pain management, and podiatric surgery services within the GSA.

In support of this application, the Applicant has provided a physician referral letter from Tom Stanley, M.D., M.P.H., FAAOS, on behalf of himself and the physicians of Orthollinois Surgery Center of Elgin, documenting historical referrals for orthopedic, pain management, and podiatric surgical services provided at existing IDPH-licensed ASTCs, hospital outpatient departments, and hospital inpatient departments located within the GSA. The referral letters cover the twelve-month period immediately preceding submission of this application.

These historical referral patterns confirm sustained and growing demand for the proposed services and establish a clear basis for the requested expansion. The submitted documentation reflects that patient origin for the projected volume is overwhelmingly from within the GSA and does not rely on new or induced demand. Further, the estimated annual number of treatments projected to be referred to the expanded ASTC within twenty-four months of project completion does not exceed each physician's historical caseload.

The Applicant documents that the average utilization rate of the existing four operating rooms at OISC-E has equaled or exceeded the standards specified in 77 Ill. Adm. Code 1100 for each of the latest two years. During the trailing 12-month period from July 2025 through June 2026, OISC-E performed 3,860 surgical procedures in its four existing operating rooms, generating total facility utilization of approximately 7,566 hours. This reflects 4,748 hours of documented surgical time and an additional 2,818 hours of preparation and turnover time across all cases. The facility's combined utilization of 7,566 hours exceeded the 6,000-hour combined State standard by 1,566 hours, or approximately 26.1%.

Monthly case volumes during the period were consistently high, ranging from 293 to 389 cases per month and averaging approximately 328 cases per month, with no month falling below the rate necessary to sustain above-standard utilization. This consistency demonstrates that the high utilization is not attributable to seasonal spikes or one-time surges but reflects sustained, ongoing demand for surgical services at the facility.

Due to the capacity constraints of its existing four operating rooms, Orthollinois physicians have been required to refer patients to other IDPH-licensed facilities in order to receive orthopedic, pain management, and podiatric surgical services. During the trailing twelve-month period from July 2025 through June 2026, Orthollinois physicians performed 2,901 procedures at area hospitals and 79 procedures at external ambulatory surgery centers, in addition to the 3,860 cases performed at OISC-E.

These hospital-based procedures were performed by Orthollinois physicians across multiple subspecialties. In addition, Orthollinois physicians performed 79 procedures at the Algonquin Road Surgery Center, an external ASTC located in Lake in the Hills, Illinois. These cases were directed to an external ASC due to scheduling constraints at OISC-E, further evidencing the facility's capacity limitations.

The anticipated referrals to the expanded facility are based on exclusively on existing surgical volume from the prior 12-month period and conservative growth projections. As documented in the Project Services Utilization section of this application, the facility projects approximately 3,860 OISC-E cases in Year 1 and approximately 4,053 OISC-E cases in Year 2, reflecting a conservative 5% annual growth in total surgical volume. The anticipated number of referrals does not exceed any physician's experienced caseload.

The projected demand for the expanded facility is grounded in documented physician caseloads at the existing facility and conservative growth assumptions. No anticipated referral volume from other facilities was used in determining the anticipated patient volume. The proposed expansion will address the documented capacity constraints, reduce the need for referrals to other facilities, and ensure that patients within the GSA can access timely, high-quality surgical care in the cost-effective ambulatory setting

Further, the estimated annual number of treatments projected to be referred to the proposed ASTC within 24 months of project completion does not exceed each physician's historical caseload.

ATTACHMENT 24

Service Demand – Expansion of Existing ASTC Service 1110.235(c)(4)



July 29, 2026

John P. Kniery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W. Jefferson Street, Floor 2
Springfield, IL 62761

Re: Referral Letter- OrthoIllinois Surgery Center Elgin, LLC

Dear Mr. Kniery,

My name is Tom Stanley, M.D. and I am an Orthopedic Surgeon affiliated with OrthoIllinois. This letter contains the referral documentation required per 77 Ill. Admin. Code Section 1110.235(c)(3)(A)-(B). During the 12 month period from January 2025 to December 2026, my colleagues and I from OrthoIllinois referred a total of 3,860 procedures to the following healthcare facilities:

Historical Caseload by Licensed setting:

Name of Healthcare Facility	Number of cases in past 12 months	OrthoIllinois Surgery Center Elgin, LLC
OrthoIllinois Surgery Center of Elgin	3,860	3,860
Advocate Sherman Hospital	1,191	0
Northwestern Medicine Huntley Hospital	831	0
Prime Healthcare Saint Joseph Hospital	731	0
OrthoIllinois Elgin	138	0
OrthoIllinois Algonquin	125	0
Ascension St. Alexius Medical Center	79	0
Algonquin Road Surgery Center	69	0
Northwestern McHenry Hospital	56	0
Valley Ambulatory Surgery Center	10	0
OSF Saint Anthony Hospital	6	0
UW Health SwedishAmerican Hospital	3	0
Northwest Community Hospital	3	0
OrthoIllinois Riverside	2	0
Advocate Good Shepherd Hospital	1	0
External Facilities Grand Total	3,245	0
Total	7,105	3,860

Based on my historical referrals, our facility anticipates 3,860 referred patients each year to **OrthoIllinois Surgery Center Elgin**. Enclosed with this letter is a list of patient origin by zip code of residence. I certify that the patients I propose to refer reside within the applicant's proposed geographic service area.

I further certify that the aforementioned referrals have not been used to support another pending or approved certificate of need permit application. The information provided in this letter is true and accurate to the best of my knowledge.

CLINIC LOCATIONS

ALGONQUIN
650 S. Randall Rd.

ELGIN
1550 N. Randall Rd.

MCHENRY
411 W. Shamrock Ln., Suite 103

ROCKFORD
2902 McFarland Rd., #300
5875 E. Riverside Blvd.
324 Roxbury Rd.

ATTACHMENT 24
Service Demand – Expansion of Existing ASTC Service 1110.235(c)(4)



Thank you,

Tom Stanley, M.D.

Physician's Signature  Date 7/29/2026

(Please Print/Type Name) Mary Lynn Reinen
Signature of Notary:

Subscribed and sworn to before me this 29th day of July



Seal

CLINIC LOCATIONS

ALGONQUIN
650 S. Randall Rd.

ELGIN
1550 N. Randall Rd.

MCHENRY
411 W. Shamrock Ln., Suite 103

ROCKFORD
2902 McFarland Rd., #300
5875 E. Riverside Blvd.
324 Roxbury Rd.

ATTACHMENT 24

Non-Hospital Based Ambulatory Surgery - Treatment Room Assessment 1110.2351110.235(C)(4)

The annual utilization expected of an ASTC is 1,500 hours per surgical or procedure room. The proposal for this facility is to establish 2 operating rooms, making the objective for demonstrating utilization in excess of 1,500 hours. Based upon documented historical utilization and a conservative projection of patient volume from proposed referrals, the Applicant anticipates that the proposed ASTC will meet and exceed the applicable utilization standard in its first year of operation, and will continue to do so in subsequent years.

UTILIZATION					
	DEPT./ SERVICE	HISTORICAL UTILIZATION (PATIENT DAYS) (TREATMENTS) ETC.	PROJECTED UTILIZATION	STATE STANDARD	MEET STANDARD?
YEAR 1	ASTC (2 Operating Room)	799 Procedures	1,566 Hours	> 1,500 Hours	Yes
YEAR 2	ASTC (2 Operating Room)	992 Procedures	1,944 Hours	> 1,500 Hours	Yes

The projected 799 procedures in Year 1 are derived exclusively from patients currently served by OrthoIllinois Surgery Center Elgin physicians and represent procedures that are already being performed at OrthoIllinois Surgery Center Elgin itself. In the most recent 12-month period, OrthoIllinois Surgery Center Elgin physicians saw 7,105 cases with 3,860 occurring at OrthoIllinois Surgery Center Elgin, demonstrating a well-established base of existing demand. Using the average procedure time and operating room preparation time based on the historical volume of procedures performed during the most recent 12 months it equals approximately 7,566 total surgical hours. This historical utilization demonstrates that the projected referrals represent only a portion of existing volume for a subsection of Orthopedic, Pain Management, and Podiatry treatment of options, rather than new or speculative demand.

The projected Year 1 utilization of 799 procedures equates to approximately 1,566 hours including preparation and clean up time. The projected Year 2 utilization of 992 procedures equates to approximately 1,944 procedure hours, based on the same average procedure time. The utilization projections for this project are based on documented historical patient volume, reflect procedures already being performed in the community, and rely on conservative assumption of 5% growth from Year 1 to Year 2 of operation. The Applicant respectfully submits that the proposed project meets the applicable utilization standards by Year 1 of operation for one operating rooms, justifying the need for both rooms proposed by this project.

ATTACHMENT 24
Non-Hospital Based Ambulatory Surgery -
Treatment Room Assessment 1110.235(C)(4)

State Standard for One Operating Room (in hours)	1500
Proposed Facility Utilization (in minutes)	453,936
Proposed Facility Utilization Year 1 (in hours)	7,566
Proposed Facility Utilization Year 2 (in hours)	7,944
Total Projected Referrals in Year 1	7,105
Total Projected Referrals in Year 2	7,460
Operational Days	250
Average Hours of Operation	7.5
Total Available Procedure Hours (Per Operating Room)	1875
Number of Operating Rooms	6
First Year Proposed Procedures	799
First Year Utilization (Operating Room 1)	80%
First Year Utilization (Operating Room 2)	3.5%
Second Year Proposed Procedures	992
Second Year Utilization (Operating Room 1)	80%
Second Year Utilization (Operating Room 2)	23.7%

Attachment 24

Staffing – 1110.235(c)(8)

The Applicant has carefully evaluated the clinical and professional staffing requirements necessary to support the proposed expansion of the OrthoIllinois Surgery Center Elgin (“ASTC”) and has determined that sufficient staffing resources are available to ensure safe, efficient, and compliant operations. The proposed staffing model has been developed in accordance with applicable licensure requirements of the Illinois Department of Public Health (“IDPH”) and the standards of nationally recognized accrediting organizations.

The ASTC will be staffed by a multidisciplinary team of qualified healthcare professionals, including registered nurses, surgical technicians, anesthesia providers, and administrative personnel. Clinical staffing will be structured to support two additional operating rooms and will include circulating nurses, scrub personnel, and recovery room staff with experience in ambulatory surgical settings. Anesthesia services will be provided by qualified anesthesiologists, physician assistants and/or certified registered nurse anesthetists (CRNAs), consistent with the types of procedures to be performed at the facility. The facility will be utilizing a similar staffing model already employed at the ASTC.

The proposed facility is located within the City of Elgin, a large metropolitan area with a well-established healthcare workforce. The availability of experienced clinical personnel in the region supports the Applicant’s ability to recruit and retain qualified staff, as needed.

In addition, the Applicant has already implemented and utilized standard recruitment strategies, including targeted outreach to experienced ambulatory surgical personnel, engagement with local healthcare training programs, and utilization of professional staffing networks. These recruitment techniques have allowed the practice to support its already existing 4 operating rooms and 11 recovery stations.

The Applicant will ensure that all staff meet applicable licensure, certification, and credentialing requirements, and will implement policies and procedures consistent with IDPH regulations and accrediting body standards. Ongoing training and competency assessments will be conducted to maintain high standards of patient care and safety.

Dr. Tom Stanley., will serve as the Medical Director of the proposed ASTC. Dr. Tom Stanley, MD, is a distinguished orthopedic spine surgeon and has extensive experience in performing minimally invasive interventional pain procedures and related surgical services.

Attachment 24
Charge Commitment – 1110.235(c)(8)



July 29, 2026

John P. Kniery
Illinois Health Facilities and Service Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: OrthoIllinois Surgery Center Elgin, LLC – Charge Commitment

Dear Mr. Kniery,

As a representative of OrthoIllinois Surgery Center Elgin, LLC, I, Anthony Brown, hereby attest that a peer review program exists or will be implemented that evaluates whether patient outcomes are consistent with quality standards established by professional organizations for ASTC services, and if outcomes do not meet or exceed those standards, that a quality improvement plan will be initiated.

Furthermore, I hereby attest that in order to meet the objects of the Illinois Health Facilities Planning Act, which are to improve the financial ability of the public to obtain necessary health services; and to establish an orderly and comprehensive health care delivery system that will guarantee the availability of quality health care to the general public; and cost containment and support for safety net services that we have enclosed a list of CPT codes and a proposed fee schedule. We hereby commit that the charges will not increase, at a minimum, for the first 2 years of operation unless a permit is first obtained pursuant to 77 Ill. Admin. Code §1130.310(a).

Sincerely,

Anthony Brown
Chief Executive Officer
OrthoIllinois Surgery Center Elgin, LLC

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Attachment 24

Charge Commitment – 1110.235(c)(8)

CPT Code	Description
10061	Incision and drainage of abscess; complicated or multiple
10120	Incision and removal of foreign body, subcutaneous tissues; simple
10121	Incision and removal of foreign body, subcutaneous tissues; complicated
10140	Incision and drainage of hematoma, seroma or fluid collection
11042	Debridement, subcutaneous tissue; first 20 sq cm or less
11043	Debridement, muscle and/or fascia; first 20 sq cm or less
11044	Debridement, bone; first 20 sq cm or less
11423	Excision, benign lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.6 to 1.0 cm
11424	Excision, benign lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 1.1 to 2.0 cm
11730	Avulsion of nail plate, partial or complete, simple; single
11760	Repair of nail bed
12020	Treatment of superficial wound dehiscence; simple closure
13160	Secondary closure of surgical wound or dehiscence, extensive or complicated
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; defect 10 sq cm or less
20525	Removal of foreign body in muscle or tendon sheath; deep or complicated
20670	Removal of implant; superficial
20680	Removal of implant; deep
20694	Removal of fixation device under anesthesia requiring separate incision
20900	Bone graft, any donor area; minor or small
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2
22558	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophylectomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace
22612	Arthrodesis, posterior or posterolateral technique, single level; lumbar
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace, single interspace and segment; lumbar
22856	Total disc arthroplasty, anterior approach, including discectomy; single interspace, cervical
22864	Total disc arthroplasty, anterior approach, including discectomy; second level, cervical
23030	Incision and drainage, shoulder area; deep abscess or hematoma
23076	Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater
23120	Claviculectomy; partial

CPT Code	Description
23333	Removal of foreign body, shoulder; deep
23395	Muscle transfer, any type, shoulder or upper arm; single
23405	Tenotomy, shoulder area; single tendon
23412	Repair of ruptured musculotendinous cuff; open, chronic
23430	Tenodesis of long tendon of biceps
23460	Capsulorrhaphy, anterior; Putti-Platt procedure or Magnuson type operation
23462	Capsulorrhaphy, anterior, any type; with bone block
23466	Capsulorrhaphy, glenohumeral joint, any type; multidirectional instability
23470	Arthroplasty, glenohumeral joint; hemiarthroplasty
23472	Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement)
23473	Revision of total shoulder arthroplasty, including allograft when performed; humeral or glenoid component
23515	Open treatment of clavicular fracture, includes internal fixation, when performed
23550	Open treatment of acromioclavicular dislocation, acute or chronic
23615	Open treatment of proximal humeral fracture, includes internal fixation, when performed
23630	Open treatment of greater humeral tuberosity fracture, includes internal fixation, when performed
23655	Closed treatment of shoulder dislocation, with manipulation, requiring anesthesia
23700	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus
24076	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; 3 cm or greater
24105	Excision, olecranon bursa
24147	Partial excision of bone, olecranon process
24300	Manipulation, elbow, under anesthesia
24341	Repair, tendon or muscle, upper arm or elbow, each tendon or muscle, primary or secondary; without free graft
24342	Reinsertion of ruptured biceps or triceps tendon, distal, with or without tendon graft
24343	Repair lateral collateral ligament, elbow, with local tissue
24345	Repair medial collateral ligament, elbow, with local tissue
24357	Percutaneous skeletal fixation of humeral epicondylar fracture, medial or lateral
24358	Open treatment of humeral epicondylar fracture, medial or lateral, includes internal fixation, when performed
24359	Open treatment of humeral epicondylar fracture, medial or lateral, with implant(s)
24360	Arthroplasty, elbow; with membrane
24575	Open treatment of humeral shaft fracture with plate/screws, with or without cerclage
24579	Open treatment of humeral shaft fracture, with insertion of intramedullary implant, with or without cerclage and/or locking screws
24615	Open treatment of acute or chronic elbow dislocation

CPT Code	Description
24635	Open treatment of Monteggia type of fracture dislocation at elbow, includes internal fixation, when performed
24666	Open treatment of distal humeral fracture, transcondylar or intercondylar, with internal fixation
24685	Open treatment of ulnar fracture, proximal end (olecranon process), includes internal fixation, when performed
25000	Incision, extensor tendon sheath, wrist
25001	Incision, flexor tendon sheath, wrist
25066	Biopsy, soft tissue of forearm and/or wrist; deep
25071	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater
25073	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial; 3 cm or greater
25075	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial; less than 3 cm
25077	Radical resection of tumor, soft tissue of forearm and/or wrist area; less than 3 cm
25078	Radical resection of tumor, soft tissue of forearm and/or wrist area; 3 cm or greater
25105	Arthrotomy, wrist joint; with synovectomy
25111	Excision of ganglion, wrist; primary
25116	Radical excision of bursa, synovia of wrist, or forearm tendon sheaths; flexors
25118	Synovectomy, extensor tendon sheath, wrist, single compartment
25215	Open treatment of carpal bone fracture (other than scaphoid or lunate), each bone
25248	Excision or curettage of cyst of carpals
25260	Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle
25310	Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon
25320	Capsulorrhaphy or reconstruction, wrist, open
25337	Reconstruction for stabilization of unstable distal ulna or distal radioulnar joint, secondary by soft tissue stabilization
25400	Repair of nonunion or malunion, radius OR ulna; without graft
25405	Repair of nonunion or malunion, radius OR ulna; with autograft
25440	Repair of nonunion or malunion, distal radius; without graft
25447	Arthroplasty, interposition, intercarpal or carpometacarpal joints
25448	Arthroplasty, interposition, wrist, with or without prosthesis; with or without autograft
25449	Revision of arthroplasty, wrist joint
25505	Open treatment of radial shaft fracture, includes internal fixation, when performed
25515	Open treatment of radial shaft fracture, includes internal fixation, when performed, and open treatment of distal radioulnar joint dislocation
25565	Open treatment of radial AND ulnar shaft fractures, with internal fixation, when performed
25575	Open treatment of distal radioulnar dislocation, acute or chronic
25606	Percutaneous skeletal fixation of distal radial fracture or epiphysis

CPT Code	Description
25607	Open treatment of distal radial extra-articular fracture or epiphysis, with internal fixation
25608	Open treatment of distal radial intra-articular fracture or epiphysis, 2 fragments, with internal fixation
25609	Open treatment of distal radial intra-articular fracture or epiphysis, 3 or more fragments, with internal fixation
25628	Open treatment of carpal scaphoid fracture, includes internal fixation, when performed
26011	Drainage of finger abscess; complicated
26040	Fasciotomy, palmar; percutaneous
26055	Tendon sheath incision
26113	Excision, tumor, soft tissue of hand or finger, subcutaneous; each additional 1.5 cm or less
26115	Excision, tumor or vascular malformation, soft tissue of hand or finger, subfascial; less than 1.5 cm
26116	Excision, tumor or vascular malformation, soft tissue of hand or finger, subfascial; 1.5 cm or greater
26121	Fasciotomy, palm only, open; partial
26123	Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint
26135	Synovectomy, metacarpophalangeal joint; each additional joint
26145	Synovectomy, tendon sheath, radical, flexor tendon, palm and/or finger, each tendon
26160	Excision of lesion of tendon sheath or capsule, hand or finger
26235	Partial excision of bone, proximal or middle phalanx of finger
26350	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath; primary or secondary without free graft, each tendon
26357	Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath; secondary, with free graft, each tendon
26370	Repair or advancement of profundus tendon, with intact superficialis tendon; primary, each tendon
26372	Repair or advancement of profundus tendon, with intact superficialis tendon; secondary with free graft, each tendon
26410	Repair, extensor tendon, hand, primary or secondary; without free graft, each tendon
26418	Repair, extensor tendon, finger, primary or secondary; without free graft, each tendon
26432	Closed treatment of distal extensor tendon insertion avulsion; with or without percutaneous pinning
26437	Realignment of extensor tendon, hand, each tendon
26440	Tenolysis, flexor tendon; palm OR finger, each tendon
26449	Tenolysis, complex, extensor tendon, finger, including forearm, each tendon
26471	Tenodesis; of proximal interphalangeal joint, each joint
26480	Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon
26531	Arthroplasty, metacarpophalangeal joint; with prosthetic implant
26536	Arthroplasty, interphalangeal joint; with prosthetic implant
26540	Repair of collateral ligament, metacarpophalangeal or interphalangeal joint
26541	Reconstruction, collateral ligament, metacarpophalangeal joint, single; with tendon or fascial graft

CPT Code	Description
26548	Reconstruction, collateral ligament, interphalangeal joint, single, including graft, each joint
26608	Percutaneous skeletal fixation of metacarpal fracture, each bone
26615	Open treatment of metacarpal fracture, single, includes internal fixation, when performed, each bone
26676	Percutaneous skeletal fixation of distal phalangeal fracture, each
26705	Closed treatment of metacarpophalangeal dislocation, single, with manipulation; requiring anesthesia
26727	Percutaneous skeletal fixation of unstable phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, with manipulation, each
26735	Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb, includes internal fixation, when performed, each
26756	Percutaneous skeletal fixation of distal phalangeal fracture, finger or thumb, each
26765	Open treatment of distal phalangeal fracture, finger or thumb, includes internal fixation, when performed, each
26785	Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single
26841	Arthrodesis, carpometacarpal joint, thumb, with or without internal fixation
26860	Arthrodesis, interphalangeal joint, with or without internal fixation
26951	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies
26952	Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with local advancement flaps
26989	Unlisted procedure, hands or fingers
27130	Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft
27132	Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive
27299	Unlisted procedure, pelvis or hip joint
27340	Excision, prepatellar bursa
27347	Excision of lesion of meniscus or capsule of knee joint
27355	Excision or curettage of bone cyst or benign tumor, femur
27380	Suture of infrapatellar tendon; primary
27385	Suture of quadriceps or hamstring muscle rupture; primary
27386	Suture of quadriceps or hamstring muscle rupture; secondary reconstruction
27405	Repair, primary, torn ligament and/or capsule, knee; collateral
27412	Autologous chondrocyte implantation, knee
27415	Osteochondral allograft, knee, open
27422	Autologous osteochondral mosaicplasty, knee (includes harvesting of autograft)
27427	Ligamentous reconstruction (augmentation), knee; extra-articular
27428	Ligamentous reconstruction (augmentation), knee; intra-articular (open)
27446	Arthroplasty, knee, condyle and plateau; medial OR lateral compartment

CPT Code	Description
27447	Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)
27477	Arrest, epiphyseal, any method; tibia and fibula, proximal
27485	Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula
27486	Revision of total knee arthroplasty, with or without allograft; one component
27498	Decompression fasciotomy, thigh and/or knee, 1 compartment
27524	Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair
27570	Manipulation of knee joint under general anesthesia
27625	Arthrotomy, with synovectomy, ankle
27635	Open treatment of tibial fracture, proximal, includes internal fixation, when performed
27650	Repair, primary, open or percutaneous, ruptured Achilles tendon
27652	Repair, secondary, Achilles tendon, with or without graft
27659	Repair, flexor tendon, leg; secondary, with or without graft, each
27665	Repair, flexor tendon, leg; secondary with graft, each
27680	Tenolysis, flexor or extensor tendon, leg and/or ankle; single, each tendon
27691	Transfer or transplant of single tendon (with muscle redirection or rerouting); deep
27695	Repair, primary, disrupted ligament, ankle; collateral
27698	Repair, secondary, disrupted ligament, ankle, collateral; with free graft
27702	Arthroplasty, ankle; with implant (total ankle)
27726	Repair of fibular nonunion and/or malunion with internal fixation
27758	Open treatment of tibial shaft fracture, with plate/screws, with or without cerclage
27766	Open treatment of medial malleolus fracture, includes internal fixation, when performed
27792	Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed
27814	Open treatment of bimalleolar ankle fracture, includes internal fixation, when performed
27822	Open treatment of trimalleolar ankle fracture, includes internal fixation, medial and/or lateral malleolus; without fixation of posterior lip
27823	Open treatment of trimalleolar ankle fracture, includes internal fixation, medial and/or lateral malleolus; with fixation of posterior lip
27827	Open treatment of fracture of weight bearing articular surface/portion of distal tibia, with internal fixation, when performed; of tibia only
27829	Open treatment of distal tibiofibular joint disruption, includes internal fixation, when performed
28039	Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm
28070	Synovectomy; metatarsophalangeal joint, each
28072	Synovectomy; interphalangeal joint, each, toe
28088	Synovectomy, tendon sheath, foot; flexor
28100	Excision or curettage of bone cyst or benign tumor, talus or calcaneus

CPT Code	Description
28103	Excision or curettage of bone cyst or benign tumor, tarsal or metatarsal, except talus or calcaneus
28104	Excision or curettage of bone cyst or benign tumor, phalanges of foot
28113	Osteotomy, complete excision; metatarsal head, fifth
28114	Osteotomy, complete excision; all metatarsal heads, with partial proximal phalangectomy
28122	Partial excision of tarsal or metatarsal bone, except talus or calcaneus
28210	Radical resection of tumor, soft tissue of foot or toe; less than 3 cm
28285	Correction, hammertoe; by phalangeal head resection, each toe
28300	Osteotomy; calcaneus, with or without internal fixation
28305	Osteotomy; with bone graft, tarsal bone (except calcaneus)
28308	Osteotomy, with or without lengthening, shortening or angular correction, metatarsal; other than first metatarsal, each
28465	Open treatment of tarsal bone fracture, includes internal fixation, when performed, each
28485	Open treatment of metatarsal fracture, includes internal fixation, when performed, each
28715	Arthrodesis; triple
28725	Arthrodesis; subtalar
28730	Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse; without osteotomy
28750	Arthrodesis, great toe; metatarsophalangeal joint
28755	Arthrodesis, great toe; interphalangeal joint
29806	Arthroscopy, shoulder, surgical; capsulorrhaphy
29807	Arthroscopy, shoulder, surgical; repair of SLAP lesion
29822	Arthroscopy, shoulder, surgical; debridement, limited
29823	Arthroscopy, shoulder, surgical; debridement, extensive
29824	Arthroscopy, shoulder, surgical; distal claviclectomy including distal articular surface
29825	Arthroscopy, shoulder, surgical; with lysis and resection of adhesions, with or without manipulation
29827	Arthroscopy, shoulder, surgical; with rotator cuff repair
29828	Arthroscopy, shoulder, surgical; biceps tenodesis
29837	Arthroscopy, elbow, surgical; debridement, limited
29838	Arthroscopy, elbow, surgical; debridement, extensive
29845	Arthroscopy, knee, surgical; synovectomy, limited
29846	Arthroscopy, knee, surgical; excision of plica
29848	Arthroscopy, wrist, surgical; excision of loose body
29870	Arthroscopy, knee, diagnostic, with or without synovial biopsy
29874	Arthroscopy, knee, surgical; for removal of loose body or foreign body
29875	Arthroscopy, knee, surgical; synovectomy, limited
29877	Arthroscopy, knee, surgical; debridement/shaving of articular cartilage

CPT Code	Description
29880	Arthroscopy, knee, surgical; with meniscectomy including any meniscal shaving; medial OR lateral
29881	Arthroscopy, knee, surgical; with meniscectomy including any meniscal shaving; medial AND lateral
29882	Arthroscopy, knee, surgical; with meniscus repair, medial OR lateral
29884	Arthroscopy, knee, surgical; with lysis of adhesions, with or without manipulation
29887	Arthroscopy, knee, surgical; drilling for intact osteochondritis dissecans lesion
29888	Arthroscopy, knee, surgical; with anterior cruciate ligament reconstruction/augmentation with or without meniscal repair or reconstruction
29889	Arthroscopy, knee, surgical; with posterior cruciate ligament reconstruction/augmentation
29895	Arthroscopy, ankle, surgical; synovectomy, partial
29898	Arthroscopy, ankle, surgical; debridement, extensive
29901	Arthroscopy, metacarpophalangeal joint, surgical; with debridement
29914	Arthroscopy, hip, surgical; with femoroplasty
29915	Arthroscopy, hip, surgical; with acetabuloplasty
29916	Arthroscopy, hip, surgical; with labral repair
29999	Unlisted procedure, arthroscopy
63001	Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy; 1 or 2 vertebral segments, cervical
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar
63042	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration; lumbar
63045	Laminectomy, facetectomy and foraminotomy, 1 or 2 vertebral segments; cervical
63046	Laminectomy, facetectomy and foraminotomy, 1 or 2 vertebral segments; thoracic
63047	Laminectomy, facetectomy and foraminotomy, 1 or 2 vertebral segments; lumbar
63056	Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s); lumbar, each additional segment
63650	Percutaneous implantation of neurostimulator electrode array, epidural
63661	Removal of spinal neurostimulator electrode percutaneous array(s)
63685	Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
63688	Revision or removal of implanted spinal neurostimulator pulse generator or receiver
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance, lumbar or sacral, single level
64702	Neuroplasty; digital, one or both, same digit
64708	Neuroplasty, major peripheral nerve, arm or leg, open; other than specified
64718	Neuroplasty and/or transposition; ulnar nerve at elbow

CPT Code	Description
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel
64772	Transection or avulsion of other spinal nerve, extradural
64831	Suture of digital nerve, hand or foot; one nerve
64907	Nerve repair; with nerve allograft, each additional nerve strand

Attachment 24
Assurances – 1110.235(c)(8)



July 29, 2026

John P. Kniery

Illinois Health Facilities and Service Review Board

525 West Jefferson Street, 2nd Floor

Springfield, Illinois 62761

Re: OrthoIllinois Surgery Center Elgin, LLC – Assurances

Dear Mr. Kniery,

As a representative of OrthoIllinois Surgery Center Elgin, LLC, I, Anthony Brown, hereby attest that the Applicant's full anticipation that, by the end of the second year following the proposed ambulatory surgical treatment center's opening, the proposed facility will operate at or in excess of the utilization standards identified in 77 Ill. Admin. Code §1110, Appendix B.

Sincerely,

Anthony Brown

Chief Executive Officer

OrthoIllinois Surgery Center Elgin, LLC

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Attachment 33

Availability of Funds

The proposed project will be funded by the applicants obtaining mortgage debt financing from UMB Bank, n.a., their long-time financial institution. The applicants have included a commitment letter from the bank as evidence of the availability of financing attesting to a maximum loan amount which exceeds the proposed project mortgage costs.

Attachment 33 Availability of Funds



July 29, 2026

John P. Kniery

Board Administrator

Illinois Health Facilities and Services Review Board

525 W Jefferson Street, Floor 2

Springfield, IL 62761

Re: OrthoIllinois Surgery Center Elgin, LLC

Ill. Admin. Code Section 1120.120(a) Available Funds Certification

Ill. Admin. Code Section 1120.140(a) Reasonableness of Financing Arrangements

Dear Mr. Kniery:

As representative of OrthoIllinois Surgery Center Elgin, LLC, I, Anthony Brown, hereby attest that the project costs will be \$15,719,234. OrthoIllinois Surgery Center Elgin, LLC will fund the entirety of the construction of the project and the necessary working capital and operating deficits through the first full fiscal year. OrthoIllinois Surgery Center Elgin, LLC will fund these costs with a loan from UMB Bank, n.a. and existing cash. OrthoIllinois Surgery Center Elgin, LLC has sufficient and readily accessible internal resources to fund the obligation required by the project.

I further certify that our analysis of the funding options for this project reflected that the funding strategy outlined herein is the lowest net cost option available.

Sincerely,

Anthony Brown

Chief Executive Officer

OrthoIllinois Surgery Center Elgin, LLC

CLINIC LOCATIONS

ALGONQUIN

650 S. Randall Rd.

ELGIN

1550 N. Randall Rd.

MCHENRY

411 W. Shamrock Ln., Suite 103

ROCKFORD

2902 McFarland Rd., #300
5875 E. Riverside Blvd.
324 Roxbury Rd.

Attachment 33 Availability of Funds



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EXPRESSION OF INTEREST - FOR DISCUSSION PURPOSES ONLY - NOT BINDING
OrthoMidwest PLLC; OrthoIllinois Surgery Center Elgin
August 25, 2026

This **Expression of Interest** is only a summary of general terms and conditions and is intended solely for use as a basis for discussions by Borrower (defined below) and UMB Bank, n.a. ("Bank"). This **Expression of Interest** is *not* a term sheet or proposal, does *not* constitute a commitment to lend on the part of Bank or any of its affiliates, and is *not* a contract or an offer to enter into a contract by Bank or any of its affiliates. This **Expression of Interest** will *not* be deemed to obligate Bank or any of its affiliates in any manner whatsoever. This document merely describes a framework of some of the terms, conditions, covenants, representations, warranties and other provisions from which a mutually acceptable financing transaction might be structured and documented. Only definitive, written, loan and security agreements and related documentation duly executed by both Borrower and Bank in connection with any loan may be binding on Borrower and Bank.

Borrower: Elgin ASC Real Estate Ventures. Final Borrower structure subject to Bank review and approval.

TERM LOAN CREDIT FACILITY

Purpose: Provide financing (the "Term Loan") for expansion of Elgin surgery center.

Facility Amount: \$4,700,000.

Term: 60 months from closing.

Interest Rate: *FIXED RATE OPTION* 6.75%. If the Term Loan does not close within 200 days of this term sheet, the interest rate will revert to The Weekly Average Yield on U.S. Treasury Securities adjusted to a constant maturity of five (5) Years, as described in the Monday publication of the Federal Reserve Statistical Release H.15, plus 2.31%, with a floor of *QUOTED FIXED RATE*: 6.75%.

All interest will be computed on the basis of a 360-day year and the actual number of days elapsed.

Repayment: Interest only for 12 months. Thereafter, monthly payments of principal plus interest based on a 22 year amortization using the actual interest rate of 6.75%, due on the 15th day of each calendar month. All outstanding principal and accrued interest will be due at maturity.

Facility Fee: To be determined.

Prepayment

Attachment 33 Availability of Funds



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Premium: A prepayment premium will be due and owing as follows: 3% in Year 1; 2% in Year 2; and 1% in Years 3 to 5. Prepayment from normal cash flows will not be subject to premium.

Borrower: OrthoIllinois Surgery Center Elgin, LLC. Final Borrower structure subject to Bank review and approval.

TERM LOAN CREDIT FACILITY

Purpose: Provide financing (the "Term Loan") for equipment needs for Elgin surgery center expansion.

Facility Amount: \$1,125,000.

Term: 72 months from closing.

Interest Rate: *FIXED RATE OPTION* 6.75%. If the Term Loan does not close within 200 days of this term sheet, the interest rate will revert to The Weekly Average Yield on U.S. Treasury Securities adjusted to a constant maturity of five (5) Years, as described in the Monday publication of the Federal Reserve Statistical Release H.15, plus 2.31%, with a floor of *QUOTED FIXED RATE*: 6.75%.

All interest will be computed on the basis of a 360-day year and the actual number of days elapsed.

Repayment: Interest only for 12 months. Thereafter, monthly payments of principal plus interest based on a 7 year amortization using the actual interest rate of 6.75%, due on the 15th day of each calendar month. All outstanding principal and accrued interest will be due at maturity.

Facility Fee: To be determined..

Prepayment Premium: A prepayment premium will be due and owing as follows: 3% in Year 1; 2% in Year 2; and 1% in Years 3 to 7. Prepayment from normal cash flows will not be subject to premium.

Borrower: OrthoIllinois Surgery Center Elgin, LLC. Final Borrower structure subject to Bank review and approval.

TERM LOAN CREDIT FACILITY

Purpose: Provide financing (the "Term Loan") for leasehold improvements for Elgin surgery center expansion.

Facility Amount: \$4,975,000.

Term: 60 months from closing.

Attachment 33 Availability of Funds



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Interest Rate: ***FIXED RATE OPTION*** 6.75%. If the Term Loan does not close within 200 days of this term sheet, the interest rate will revert to The Weekly Average Yield on U.S. Treasury Securities adjusted to a constant maturity of five (5) Years, as described in the Monday publication of the Federal Reserve Statistical Release H.15, plus 2.31%, with a floor of ***QUOTED FIXED RATE***: 6.75%.

All interest will be computed on the basis of a 360-day year and the actual number of days elapsed.

Repayment: Interest only for 12 months. Thereafter, monthly payments of principal plus interest based on a 15 year amortization using the actual interest rate of 6.75%, due on the 15th day of each calendar month. All outstanding principal and accrued interest will be due at maturity.

Facility Fee: To be determined.

Prepayment Premium: A prepayment premium will be due and owing as follows: 3% in Year 1; 2% in Year 2; and 1% in Years 3 to 5. Prepayment from normal cash flows will not be subject to premium.

OTHER TERMS AND CONDITIONS [APPLICABLE TO ALL FACILITIES]

Other Fees and Expenses: Borrower will be required to pay for all fees incurred or charged by Bank including, but not limited to, the preparation of loan documentation customary for this type of transaction [by Bank's outside legal counsel], collateral perfection, and all other expenses incurred by Bank. All fees and expenses detailed herein will be deemed earned and payable at the time of closing. In the event the proposed facilities do not close, Borrower will remain liable to Bank for all fees and expenses actually incurred by Bank and will pay the same upon request from Bank.

Collateral: All business assets of Borrower(s), including, but not limited to, accounts receivable, inventory, machinery and equipment, fixtures, real estate, contract rights, documents, instruments, and general intangibles, and other security that is customary for these types of facilities. First lien mortgage and assignment of rents, leases, property management agreement and other security that is customary for these types of facilities for the property located at 2440 Alft Lane, Elgin, IL 60124.

Guarantors: OrthoMidwest, PLCC will provide its unlimited guarantee. OrthoIllinois Surgery Center Elgin, LLC will provide its unlimited guarantee. Pro rata guarantees from each shareholder limited to a total of \$2,000,000.

Minimum Financial Covenants:

No changes to existing covenant package are anticipated at this time.

Attachment 33 Availability of Funds



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Deposit	
Account(s):	Borrower will be required to maintain its primary depository and treasury management relationship with Bank.
Reporting Requirements:	No changes to existing reporting requirements are anticipated at this time.
Insurance:	Personal property and liability insurance coverages, including umbrella and excess liability coverage naming Bank as additional insured; and such other coverages as may be required by Bank.
Other Requirements or Conditions:	The following additional requirements and conditions to closing or funding the facilities (as applicable) will be included: 1) The facilities described in this Expression of Interest are subject to final credit approval by the Senior Loan Committee of Bank (which approval may not be provided). All terms are subject to change. 2) Bank receipt, review, and approval of Guarantors and their financial statements including balance sheet, real estate schedule, global cash flow, and contingent liabilities. Bank will require liquidity to be verified via receipt of bank/brokerage statements, if needed. 3) Satisfactory completion by Bank of remaining underwriting and market due diligence typically required for these types of facilities, including, but not limited to, verification of contributed equity. 4) Subject to Bank's appraisal of the Collateral. 5) Additional market due diligence. Additional market due diligence must be acceptable to Bank in its sole and absolute discretion. 6) Subordinate liens will be prohibited without Bank's prior written consent. A subordination agreement will be required with any pre-existing lender in a form, and on terms and conditions, acceptable to Bank. 7) Receipt, review, and approval by Bank of all organizational and other due diligence documents for Borrower and each Guarantor, together with any additional entities that hold direct or indirect interests in such parties, whose consent is necessary to such parties' due authorization of the loan documents and any key members or partners of Borrower or any Guarantor as may be required by the Federal "Know Your Customer" and/or Beneficial Ownership requirements and/or as may be reasonably determined by Bank. 8) Receipt, review, and approval by Bank of such other information as Bank may reasonably request.

Attachment 36 Economic Feasibility

Included with this attachment is a letter from Anthony Brown that addresses the Reasonableness of Financing Arrangements and Conditions of Debt Financing.

Attachment 36 Economic Feasibility



July 29, 2026

John P. Kniery

Board Administrator
Illinois Health Facilities and Services Review Board
525 W Jefferson Street, Floor 2
Springfield, IL 62761

Re: Orthollinois Surgery Center Elgin, LLC
Ill. Admin. Code Section 1120.120(a) Available Funds Certification
Ill. Admin. Code Section 1120.140(a) Reasonableness of Financing Arrangements

Dear Mr. Kniery:

As representative of Orthollinois Surgery Center Elgin, LLC, I, Anthony Brown, hereby attest that the project costs will be \$15,719,234. Orthollinois Surgery Center Elgin, LLC will fund the entirety of the construction of the project and the necessary working capital and operating deficits through the first full fiscal year. Orthollinois Surgery Center Elgin, LLC will fund these costs with a loan from UMB Bank, n.a. and existing cash. Orthollinois Surgery Center Elgin, LLC has sufficient and readily accessible internal resources to fund the obligation required by the project.

I further certify that our analysis of the funding options for this project reflected that the funding strategy outlined herein is the lowest net cost option available.

Sincerely,

Anthony Brown
Chief Executive Officer
Orthollinois Surgery Center Elgin, LLC

CLINIC LOCATIONS

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324 Roxbury Rd.

Attachment 36 Economic Feasibility

COST AND GROSS SQUARE FEET BY DEPARTMENT OR SERVICE									
Department (List below)	A	B	C	D	E	F	G	H	Total Cost (G + H)
	Cost/Square Foot New	Mod.	Gross Sq. Ft. New	Circ.*	Gross Sq. Ft. Mod.	Circ.*	Const. \$ (A x C)	Mod. \$ (B x E)	
ASTC	\$509.34	-	5,400	4,551	-	-	\$2,750,458	-	\$2,750,458
Contingency	\$50.92	-	-	-	-	-	\$275,000	-	\$275,000
TOTALS	\$560.26	-	5,400	4,551	-	-	\$3,025,458	-	\$3,025,458
* Include the percentage (%) of space for circulation									

Pursuant to Illinois Administrative Code Section 1120 Appendix A (a)(3), a project's cost must be at or below the RS Means for the new construction of an ASTC. At the time of this application, the RS Means for the new construction of an ASTC in this area of the state is \$510.27 per GSF. This project is slated to be completed in the third quarter of 2028 and the applicable RS Means standard is \$510.27 per GSF. The proposed cost per GSF for this project without contingency costs is \$509.34, which meets state standards.

Attachment 37 Safety Net Impact Statement

The proposed project is a non-substantive project and the safety net impact statement is not applicable.

Attachment 38 Charity Care Information

CHARITY CARE			
	2022	2023	2024
Net Patient Revenue	-	-	\$9,057,408
Amount of Charity Care (charges)	-	-	\$6,224
Cost of Charity Care	-	-	-

The projected patient mix by payer source is based on the existing patient base seen by OrthoIllinois Surgery Center Elgin in 2028.

Projected Patient Base Payor Mix

Payor Name	% of Patients Treated at Facility
Private Insurance	46%
Medicare	45%
Medicaid	2.5%
Self-Pay	2%
Worker's Compensation	4.5%

Attachment 39 Flood Plain Information



July 29, 2026

John P. Kniery
Board Administrator
Illinois Health Facilities and Services Review Board
525 W Jefferson Street, Floor 2
Springfield, IL 62761

Re: OrthoIllinois Surgery Center Elgin - Flood Plain Requirements

Dear Mr. Kniery:

As representative of OrthoIllinois Surgery Center Elgin, LLC, I, Anthony Brown., affirm that our proposed site complies with Illinois Executive Order #2005-5. The site located at 2440 Alft Ln, Elgin, Illinois, 60124 is not located in a flood plain, as evidence please find enclosed a map from the Federal Emergency Management Agency ("FEMA").

I hereby certify this is true and is based upon my personal knowledge under penalty of perjury and in accordance with 735 ILCS 5/1-109.

Sincerely,

Anthony Brown
Chief Executive Officer
OrthoIllinois

CLINIC LOCATIONS

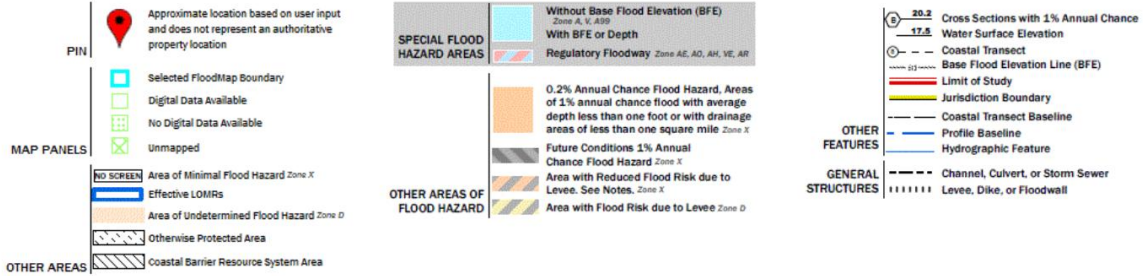
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324 Roxbury Rd.

Attachment 39
FEMA- National Flood Hazard Layer FIRMette



After paginating the entire completed application indicate, in the chart below, the page numbers for the included attachments:

INDEX OF ATTACHMENTS		
ATTACHMENT NO.		PAGES
1	Applicant Identification including Certificate of Good Standing	26
2	Site Ownership	27-28
3	Persons with 5 percent or greater interest in the licensee must be identified with the % of ownership.	29-30
4	Organizational Relationships (Organizational Chart) Certificate of Good Standing Etc.	31
5	Flood Plain Requirements	32-33
6	Historic Preservation Act Requirements	34-39
7	Project and Sources of Funds Itemization	40-44
8	Financial Commitment Document if required	45
9	Cost Space Requirements	46
11	Background of the Applicant	47-54
12	Purpose of the Project	55-88
13	Alternatives to the Project	89-90
14	Size of the Project	91
15	Project Service Utilization	92-93
16	Unfinished or Shell Space	94
17	Assurances for Unfinished/Shell Space	95
24	Non-Hospital Based Ambulatory Surgery	96-117
33	Availability of Funds	118-123
36	Economic Feasibility	124-126
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39	Flood Plain Information	129-130